Known Defects and Anomalies

Revision History

Date	Revision	Description	Author
7-21-06	1.0	Initial Version	BBM team
6-22-07	2.0	Deleted CRs 1,051, 1,373, 1,441, 1,625, 1,691, 1,709, 1,736, 1,756, 1,791, 1,801, 1,804, 1,826, 1,847, 1,855, 1,859, 1,922, 1,939, 1,957, 1,982, 1,983, 1,986, 1,987, 1,988, 2,031, 2,057, 2,060, and 2,061. Deleted CR 457 and CR 1,512, included in error in the 1.0 version of this document. Added CRs 1,858, 2,022, 2,030, 2,070, 2,074, 2,076, 2,078, 2,083, 2,084, 2,085, 2,086, 2,089, 2,092, 2,093, 2,096, 2,098, 2,100, 2,101, 2,103, 2,105, 2,106, 2,107, 2,109, 2,110, 2,111, 2,114, 2,115, 2,116, 2,119, 2,120, 2,123, 2,129, 2,130, 2,131, 2,133, 2,134, 2,135, 2,136, 2,145, 2,148, 2,149, 2,153, 2,158, 2,159, 2,168, 2,177, 2,179, 2,180, 2,181, 2,185, 2,186, 2,188, 2,200, 2,201, 2,202, 2,203, 2,209, 2,215, 2,216, 2,217, 2,218, 2,219, 2,220, 2,221, 2,223, 2,224, 2,225, 2,226, 2,227, 2,230, 2,231, 2,233, 2,236, 2,237, 2,240, 2,241, 2,242, 2,243, 2,244, 2,247, 2,248, 2,251, 2,252, 2,253, and 2,254, and 2,255. Added DRs 1,230, 1,312, 1,322, 1,625, 1,632, 1,633, 1,640, 1,641, 1,643, 1,651, 1,661, 1,703, 1,704, 1,707, 1,729, 1,942, 1,956, 1,967, 1,984, 2,020, 2,072, 2,133, 2,135, 2,140, 2,152, 2,206, 2,218, 2,255, 2,323, 2,479, 2,536, 2,539, 2,257, 2,580, 2,584, 2,586, 2,602, 2,605, 2,616, 2,618, 2,681, and 2,703.	BBM team
2/25/08	3.0	Updated for the release of VBECS 1.2.0.0: Combined Known Defects and Anomalies section into one and added a column to identify anomaly vs. defect. Added column for CR/DR numbers. Separated CR and DR numbers from the description. Added a column to separate workaround and comments. Changed all No workaround available to None available as the column only contains workarounds. Consolidated Configure Initial Division Parameters, Configure Interfaces, Configure System Administrators and Define Interface Control Parameters under VBECS Administrator section. Consolidated CR 2,115 with throughout VBECS audible alert. Deleted CRs 1,352, 1,805, 1,844, 1,874, 1,904, 1,947, 1,977, 1,979, 2,009, 2,091, 2,110, 2,134, 2,155, 2,251, 2,186, 2,188, 2,248, 2,253, 1,857, 2,356, 1,533, 1,883, 1,109, 1,856, 1,870, 1,161, 1,602, 1,651, 1,858. Deleted DRs 2,135, 2,255, 2,257. Added CRs 1,828, 2,065, 2,095, 2,113, 2,118, 2,190, 2,193, 2,195, 2,199, 2,208, 2,233, 2,234, 2,257, 2,259, 2,261, 2,262, 2,263, 2,270, 2,273, 2,281, 2,282, 2,286, 2,295, 2,309, 2,310, 2,318, 2,330, 2,337, 2,340, 2,344, 2,347, 2,348, 2,353, 2,354, 2,356, 2,359, 2,361, 2,363, 2,366, 2,367, 2,368, 2,370, 2,372, 2,376, 2,385, 2,387. Added DRs 1,707, 2,672, 2,679, 2,690, 2,735, 2,821, 2,851, 2,881, 2,883, 2,891, 2,937, and 2,982. Made multiple grammatic and format changes throughout the document. Edited workaround text in CR 1,824, CR 2,334, CR 2,353, CR 1,949, CR 2,185, CR 1,976, CR 2,286, CR 2,337, CR 2,387, CR 2,363, CR 1,902 and CR 1,950. Combined CR 2,353 and CR1,824 Revised the description of CR 2, 334, CR 2,310, CR 2,131, CR 1,897, DR 2,536, CR 2,333, DR 2,881, CR 2,361, CR 1,797, CR 2,053, CR 2,070, CR 1,515, CR 1,548, CR 2,120, CR 2,041, CR 2,083, CR 1,961, CR 1,963, CR 2,003, CR 2,051, CR 2,220 Revised all DR 2,891, DR 2,681, DR 2,133 CR 1,853, DR 1,643, CR 2,032,	BBM team

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number)

Date	Revision	Description	Author
		Moved CR 2130 to the section “CPRS”. Moved CR 2042 to the section “Record Patient ABO/Rh”. Changed the heading of the section from Record Patient ABO/Rh to “Patient Testing: Record Patient ABO/Rh”. Moved the section to Patient Testing section. Moved DR 1,322 to the Incoming Shipment section. Separated the comment from the workaround for CR 2148, DR 1,230 Combined CR 2,240 and CR 2,244 Combined Special Instructions/Transfusion Requirements sections. Removed comment from CR 1,890, CR 2,085 Added comment to CR 2,359, CR 2,254, CR 1,846 “Not Related to the User Interface” section changed to “Server System Administrator”.	
4/01/08	4.0	Updated for the release of VBECS 1.3.0.0. Added CR 2,384, CR 2,387, CR 2,396, CR 2,397, CR 2,401, CR 2,402, CR 2,406, CR 2,408, CR 2,410, CR 2,411.	BBM Team
4/22/08	5.0	Updated for the release of VBECS 1.3.0.0. Added CR 2,419, CR 2,422, DR 3,016, DR 3,041, DR 3,046 Edited DR 2,891 workaround and comments.	BBM Team
6/17/08	6.0	Updated for the release of VBECS 1.4.0.0. Added CR 2,417, CR 2,433, CR 2,435, CR 2,436, CR 2,437, CR 2,438, CR 2,443, CR 2,448 and CR 2,454. Edited CR 2,422. Removed CR 1,904, CR 2,419, DR 3,016,CR 2,130, CR 2,237	BBM Team
7/11/08	7.0	Updated for the release of VBECS 1.4.0.0. Added DR 3,124.	BBM Team
7/17/08	8.0	Updated for the release of VBECS 1.4.0.0: Added CR 2,462.	BBM Team
9/19/08	9.0	Updated for the full install release: Added CR 2,421, CR 2,451, CR 2,455, CR 2,456, CR 2,459, CR 2,461, CR 2,463, CR 2,466, CR 2,467, CR 2,483, CR 2,484, CR 2,485, CR 2,490, CR 2,494, CR 2,500, CR 2,501 CR 2,385, CR 2,489, CR 2,499, CR 2,502, CR 2,425, CR 2,105. Added DR 3,098. Removed DR 2,618, DR 3,124, DR 3,041 Added the hyphen to Post-Transfusion for consistency	BBM Team
1/13/09	10.0	Added additional introduction. Per feedback from the Patient Safety Office review: added columns for Risk Assessment/Impact to Patient Care, Security Role Mitigations (Affected User), and Tentative Schedule for correction. Moved explanatory text from the workaround column to the comments column and added additional comments. Options put in alphabetical order. CR 1,514, moved from Server System Administrator to Throughout VBECS section. CR 2,262, Recommended Workaround, removed space before “When”. CR 1,212, Additional Comments, changed “The use cannot” to “The user cannot” CR 2,092, Security Role Mitigations, Reworded. CR 1,628, Additional Comments, added a period. CR 1,925, Additional Comments, removed space before “Requires” DR 2,020, Description, changed “of” to “or”. CR 1,501, and CR 1,514, Additional Comments, added the hyphen to “non-patient”. Removed DR 2,347, and 2,672.	BBM Team

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Introduction

The Known Defects and Anomalies (KDAs) table consists of system actions that do not meet performance expectations established in VBECS design documents. Some defects and anomalies require user workarounds such as being directed to view information in one report that was expected in another report. Defects and anomalies do not require a workaround if the software performs acceptably. All defects and anomalies are classified as minor (no expectation of injury to the patient, operator, or bystander as a result of software failure) or the workaround sufficiently mitigates the defect to an acceptable risk.

Note: All system errors/shutdowns occur where the user would normally be prohibited from proceeding to process the unit or patient in VBECS; training users to STOP and evaluate the correctness of the action is strongly recommended.

Related Manuals and Materials

- *VistA Blood Establishment Computer Software (VBECS) Installation Guide*
- *VistA Blood Establishment Computer Software (VBECS) Technical Manual-Security Guide*
- *VistA Blood Establishment Computer Software (VBECS) User Guide* (The KDAs are referenced as *Appendix E* but are maintained with a separate revision table).

How the Known Defects and Anomalies is Organized

- The table is organized by the option where the issue occurs in VBECS.
- Description of the Issue, Risk Assessment, and Affected Security Role columns provide pertinent information about the defect or anomaly.
- Recommended Workarounds are provided with the Additional Comments column providing more detail as needed.
- Highlighted rows indicate that the issue was reported during field testing. The Tracking System Number is used internally by the development team and may be used in the future when patch releases are announced.
- Tentative Schedule column contains the projected release where the anomaly will be corrected.
- Throughout VBECS is the only section where the item may occur in various places in the application not in just one option. These occur intermittently.

Terms

See the VBECS User Guide Glossary for definitions of other terms and acronyms used in this table.

Security

Six security roles are available in VBECS. Security Levels and User Roles from most to least restrictive are: Blood Bank Technologist (most restrictive), Enhanced Technologist, Lead Technologist, Traditional Supervisor, Enhanced Supervisor, Administrator/Supervisor (least restrictive).

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In order to simplify this analysis three categories may be used to clarify the AFFECTED USER category: Administrator (Administrative Supervisor and Enhanced Supervisor); Supervisor (Traditional Supervisor and Lead Technologist, and above); All Users (Enhanced Technologist and Technologist, and above). Additional users are a System Administrator (Windows Network Administrator) and a VBECS Administrator (Server Administrator) which are restricted, usually to a primary and a backup person.

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Through-out VBECS	VBECS will display a system error message and will not function if the administrator sets a future date in VBECS settings.	Very Low risk/Low impact.	All users	VBECS Administrators must set the date on the server to a current or past date. Verification of settings is recommended.	This is identified immediately by the first user logged into the system in Test and in Production.	CR 2,153	Maintenance TBD
Through-out VBECS	VBECS service monitor is not cluster aware. If the VBECS server fails over, services will not automatically restart.	Low risk/Low impact.	All users	Restart the services after VBECS experiences failover. System administrator action is required.	Although the switch is made to the redundant server, connectivity to other systems (e.g., VistA) is not restored automatically. VBECS administrator is informed of the failure of connections via messaging in VistA. Orders may not appear as expected when the services are not restarted. Notify VBECS administrator, per local policy.	CR 2,065	1.5.0.0
Through-out VBECS	An audible alert may not occur when VBECS prevents the user from accessing a selected option or proceeding with a process.	No identified risk/No identified impact.	All users. Varies with the specific affected options, some of which have restricted access.	None required as users can not proceed until override is satisfied. A visual alert is presented to the user indicating why they may or may not proceed with the process.	Audible alerts are used throughout VBECS as a secondary alert to the user when an override is required.	CR 2,033, CR 1,893, CR 2,045, CR 2,038, CR 2,014, CR 2,017, CR 2,019, CR 2,115, CR 2,193, CR 2,195, CR 2,199	Maintenance TBD
Through-out VBECS	Blood unit status is calculated dynamically to allow different operations on a single blood unit at the same time. While the described model is working, this feature can cause performance issues in queries involving blood unit status.	No identified risk/Low impact.	All users	Limit queries of the database to single unit status or a small date range for larger reports to optimize performance. Schedule the report to print at a future time.	Large queries may cause delays (seconds to minutes) in data return that is noticeable to the user as they expect immediate return of information.	CR 1,174	Maintenance TBD
Through-out VBECS	Printed reports in VBECS use gray lines to designate the end of patient or unit data. The lines should be darker to make reading the report easier.	No identified risk/ No identified impact.	System Administrator	None required.	The shading on screen and in printed form varies with the monitor and printer settings.	CR 1,514	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Through-out VBECS	On some reports, VBECS prints the page number but does not include the total number of pages printed (e.g., 1 of 75).	No identified risk/No identified impact.	All users	None required. The total number of report pages display in the print preview and may be used to verify that a complete report has printed.	User may elect to manually update page numbers on impacted reports.	CR 1,967, CR 2,021	Report Tool Upgrade Proposal
Through-out VBECS	If the user enters a full last name and clicks the ellipsis to search for a patient when entering a unit in Incoming Shipment, VBECS retrieves patients that match the entered name along with others that match the first four letters of the searched name.	Low risk/Low impact.	All users	None required as our feedback from the field sites and other user groups is that the user is trained to enter the full SSN for a patient and not use a pick list to select a patient for any option in VistA or VBECS.	The returned search results are displayed with the best matches at the top of the list. User may have a longer patient list presented to find the required patient.	CR 1,635	Report Tool Upgrade Project Proposal
Through-out VBECS	When a 10-character last name is entered in the Patient Select Tool, VBECS looks for a specimen UID.	No identified risk/Low impact.	All users	Feedback from the field sites and other user groups is that the user is trained to enter the full SSN for a patient and not use a pick list to select a patient for any option in VistA or VBECS. Search by the initial of the last name and last four digits of the patient ID (SSN), or the full patient ID.	Using standard patient search criteria avoids this potential confusion.	CR 2,004	Maintenance TBD
Through-out VBECS	VBECS records the standard patient name format: the first initial included in the data after the second comma, e.g., last name, first name, middle initial. This conflicts with the VistA standard patient name presentation.	No identified risk/No identified impact.	All users	None required as the patient is correctly identified and name is readable, simply formatted differently from VistA's presentation.	The patient names are not considered a unique identifier. The ID number (DFN, ICN) is used to identify the patient record. The legacy system may record data in the middle-initial field that is not included in the VBECS display of the patient name.	CR 1,903	Maintenance TBD
Through-out VBECS	When only a few non-specific characters are entered in the patient search field, no matches are found and the option times out without displaying a message to the user.	No identified risk/Low impact.	All users	Enter the full last name, or the full patient ID, last name, last name initial, and last four digits of the patient ID (SSN), or the full patient ID. User will enter standard patient search criteria.	This is not a valid search entry. As this does not result in a patient display, the user must reenter the correct search information.	CR 1,901	Maintenance TBD
Through-out VBECS	When multiple windows are overlaid in the VBECS application, they may appear incompletely drawn.	No risk/ Low impact.	All users	Minimize and maximize the VBECS application or remote desktop connection window to refresh the screen.	The user can easily identify that the data screen is incomplete and cannot use or continue until refreshed.	CR 1,771	Maintenance TBD
Through-out VBECS	Patient Search Tool does not present a deceased patient when searching by Last Name.	No risk/No impact.	All users	Search for a deceased patient using the last four of their patient ID.	Look-up of deceased patients does not impact delivery of testing or transfusions.	CR 2,443	Maintenance TBD
Through-out VBECS	The VBECS 1.3.0.0 patch created several anomalies in the displayed product name, for example, "-5d " displays as "û5d".	No risk/No impact.	All users	None required.	Format is understandable to users and does not cause confusion between blood products.	CR 2,467	1.5.0.0

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
ABO/Rh Confirma-tion	If units are selected and users change the search criteria, the selected units stay selected even if they do not match the current search criteria.	No risk/No impact.	All users	Deselect units that will not be tested in this option. Units not completely tested are not available for patient selection.	VBECS presents selected units for review prior to performing testing and entering results.	CR 1,578	Testing Grids
ABO/Rh Confirma-tion	VBECS displays “Abo/Rh” instead of “ABO/Rh” in the ABO/Rh mismatch message.	No risk/No impact.	All users	None required. Format is understandable to users.	None	CR 1,723	Testing Grids
ABO/Rh Confirma-tion	Patient assignment is not released automatically when a unit is quarantined due to discrepant ABO/Rh retype testing.	Very low risk/No impact.	All users	None required. The unit is quarantined and cannot be selected for a different patient or issued for this patient.	VBECS prevents issuance of a unit with discrepant testing. Quarantined units are clearly marked in VBECS and cannot be issued.	DR 2,982	Testing Grids
ABO/Rh Confirma-tion	A system error occurs when attempting to save Unit Confirmation tests with an invalid test between valid test results.	No identified risk/Low impact.	All users when attempting to save an invalid confirmation test in the middle of a batch.	Save and exit the option immediately after the invalid unit confirmation test row. Reenter the option and select any remaining units for testing.	User is immediately aware that system data must be reentered.	CR 2,396	Testing Grids
ABO/Rh Confirma-tion	Confirmation window buttons are inaccessible when a large batch is processed.	Low risk/Low impact.	All users	Select no more than 40 units in any batch. If a user finds themselves in this position, they need to X out of the confirmation and re enter the unit tests in smaller batches.	Most VA hospitals are low volume transfusion services and will not receive or process unit confirmation batches exceeding the display area.	CR 2,422	1.6.0.0
Accept Orders: Accept an Order	On the Accept Orders screen, clicking the Received and Wanted column headers does not sort on the date and time of the Pending Order List.	No identified risk/ No identified impact.	All users	None available.	All order information is viewable. This is the column sort function which may or may not be used. As sites have stated that they select an order by entering the specimen UID or patient information this is a rarely used search criteria.	CR 2,098	Testing Grids
Accept Orders: Accept an Order	When the user clicks Print and selects certain date ranges, a shutdown error may occur due to a Crystal Reports bug.	No identified risk/ No identified impact.	All users	Restart VBECS and reprint the report. Select a different date range to include the dates required.	All data is viewable by selecting different ranges. Crystal Reports does not publish specific elements that cause the error.	CR 1,774	Report Tool Upgrade Project Proposal
Accept Orders: Accept an Order	The emergency order check box is not enabled unless there is a CPRS order and a patient specimen accessioned in VistA.	No identified risk/Low impact.	All users	Accession the component order in VistA without the specimen to use the emergency order function in VBECS. The VistA order can then be changed when the specimen is received.	Alternately, process the emergency issue of units manually, per local policy, until the specimen is received and accessioned. Processing an emergency blood component issue is an uncommon occurrence. Generally, a specimen is collected and may be available at the time though testing may be incomplete at the time of issue depending on the patient population of a facility.	CR 1,604	Testing Grids

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Accept Orders: Accept an Order	The Evaluate MSBOS button is disabled for TAS pre-op orders. TAS only orders cannot be marked as inappropriate.	No identified risk/ No identified impact.	All users	None available.	When a surgical procedure has no TAS or component recommendation, VBECS allows the order but does not mark the request for report review. The provider has ordered a TAS when there is no pre-op recommendation.	CR 1,944	Testing Grids
Accept Orders: Accept an Order	A VBECS system error will occur when a user attempts to save a rejection comment that is longer than 255 characters.	No identified risk/ No identified impact.	All users	User must log back into VBECS and enter a comment with a message string that does not exceed 255 characters including the canned comment text.	VBECS configuration of standardized (canned) and free-text comments rarely require this message length. .	CR 2,149	Testing Grids
Accept Orders: Accept an Order	When a user cancels a component order, the tree view is updated. When the user clicks TAS, the component order is displayed in the tree view again and states that it is canceled.	No identified risk/ No identified impact.	All users	None required.	The information was not expected to appear to the user. The appearance of the information may be beneficial to the user at this processing point.	CR 1,912	Testing Grids
Accept Orders: Accept an Order	A specimen may not be marked unacceptable when Maintain Specimen is accessed during the acceptance of an order.	Low Risk/Low impact.	All users attempting to associate an unacceptable specimen with a VBECS order.	None required. The specimen may be marked unacceptable without relation to the order by using the Maintain Specimen option.	Directly access Maintain Specimen to mark a specimen unacceptable without cancelling the order. This arose from a misunderstanding of the system functionality. The specimen can be marked unacceptable and the order can be cancelled in each one's appropriate option.	DR 2,851	Maintenance TBD
Accept Orders: Pending Order List	Windows services appear to be connected but the CPRS order does not display on the Pending Order List.	Low risk/Low impact.	All users	When orders are not being received in VBECS the VBECS HL7 service must be restarted by the VBECS Administrator. Refer to the "VBECS Application Interfaces" section of the troubleshooting appendix of the VBECS technical manual-security guide, which describes several options for resolving this issue.	Ordering provider is notified that order will not be sent. A message is sent to the System Administrator to restart services. This problem mainly occurs when the primary node in the cluster is restarted. The cluster fails over but the VBECS services on the new primary server do not restart automatically.	CR 1,828 CR 2,095	1.5.0.0
Accept Orders: Pending Order List	VBECS contains an order priority of ASAP, however CPRS does not support an order urgency of ASAP so searches on this urgency will not display orders.	No identified risk/ No identified impact.	All users	None required.	Awaiting CPRS correction to include ASAP. This was a disconnect in requirements assessment.	DR 1,967	CPRS 27N Currently resolved in VBECs Assigned to 1.6.0.0 for testing closure
Accept Orders: Pending Order List	The printed version of the Pending Order List differs in appearance from the screen view.	Low risk/Low impact.	All users	None required.	The content of the Pending Order List printout is the same as the screen display.	CR 1,401	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Adminis-trative Data Report	Units received during Incoming Shipment that are split/divide when received do not display on Administrative Data Report.	Low risk/Low impact.	All users	Maintain a manual tally of split units received during Incoming Shipment as needed.	Report is not used to manage inventory or select appropriate blood for specific patients.	CR 2,103	Report Tool Upgrade Project Proposal
Adminis-trative Data Report	Units entered into the incoming shipment having CMV and Sickle Cell negative check box unchecked appear on the Administrative Data Report as having been checked. This leads to incorrect counts for CMV and Sickle Cell negative units.	Low risk/Low impact.	All users	See the Unit History Report to determine the CMV negative status of a unit. If needed, maintain a manual count of CMV negative units received during incoming shipment.	Report is not used to manage inventory or select appropriate blood for specific patients.	CR 2,105	Report Tool Upgrade Project Proposal
Antibod-ies	The Antigen Negative Compatibility Percentage field allows the entry of a decimal that causes the reversal of the entry (e.g., user entry of “1.5” becomes “51”) and may be saved.	Low risk/Low impact.	Administrator	Enter whole numbers; do not enter decimals. Check the accuracy of the entry before saving.	This data is managed by security role and is for information only.	CR 1,842	Maintenance TBD
Antibod-ies	Anti-A,B is not selectable as a patient antibody.	Low risk/Low impact.	Administrator	Users can enter the Anti-A,B antibody in the patient’s Special Instructions.	This antibody is historical from VistA and is not utilized for selection of blood components for transfusion.	CR 1,872	Maintenance TBD
Audit Trail Report	When the user inactivates a unit’s ABO/Rh confirmation test results or inactivates a unit record and enters the required comment, VBECS does not print the comment on the Audit Trail Report.	Low risk/Low impact.	Supervisor	Immediately print the Audit Trail Report for this activity and manually complete the comment; save it for review.	The inactivation is recorded and maintained. The unsaved comment does not impact patient testing or transfusion records and is an infrequent occurrence.	CR 1,824 CR 2,353	Report Tool Upgrade Project Proposal
Audit Trail Report	A system error occurs when a user starts an Audit Trail Report, VistALink is not available and the selected date range includes VBECS Administrator changes.	Low risk/Low impact.	Supervisor when VBECS administrator changes have been processed.	Confirm that VistALink is active before requesting the Audit Trail Report.	The error prompts the user to reconnect VistALink so no audit entries are missed any time the report is requested.	CR 1,671	Report Tool Upgrade Project Proposal
Audit Trail Report	Changes made to a unit’s log-in CMV or Sickle Cell status are not displayed on the report.	Low risk/No identified impact	Supervisor when a blood unit CMV or Sickle cell changes have been processed.	The initial and updated information in the Unit History Report	The change history is correctly maintained with each unit record. It is standard VBECS behavior to display this type of data change on the Audit Trail Report.	CR 2,318	Report Tool Upgrade Project Proposal
Audit Trail Report	VBECS displays only the ISBT 128 five-digit product code in the sub-headers for the Blood Unit Changes or Blood Unit Financial Changes sections of the report.	No identified risk/No identified impact	Supervisor when a blood unit changes have been processed.	None required. This is the product code without the donation type and divisions which are not required for accurate interpretation of this report entry.	The full eight-digit product code is available in the Unit History Report. Format is understandable to users.	CR 1,824	Report Tool Upgrade Project Proposal

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Audit Trail Report	Changes to a blood unit's disease marker testing do not appear in the report.	No identified risk/No identified impact .	Supervisor when a blood unit's disease marker status has been changed.	None required.	Changes to the biohazardous marker are displayed in the Edit Unit Information section, testing details are available in the Unit History Report. It is standard VBECS behavior to display this type of data change on the Audit Trail Report.	CR 1,907	Report Tool Upgrade Project Proposal
Audit Trail Report	Special Instructions and Transfusion Requirements comments may not display completely on the report.	Low risk/Low impact.	Supervisor when SI and TR have been changed (removal is security restricted to Supervisor).	None required.	The Patient History Report can be viewed for the entire comment. Although this is an infrequent occurrence, it is non-standard VBECS behavior.	CR 1,968	Report Tool Upgrade Project Proposal
Audit Trail Report	VBECS allows the user to click the report header; it displays as a separate tab.	No identified risk/ No identified impact	All users who look at the print preview of the audit trail report.	None required.	This is a section header. The information is correct.	CR 1,531	Report Tool Upgrade Project Proposal
Audit Trail Report	The report displays changes to the database during MSBOS configuration even though a value was not actually changed by the user. This is due to fields in the database changing from null to NO.	No identified risk/ No identified impact	Supervisor reviewing the Audit Trail after initial configuration.	None required.	This is the day one data update of the database with the standardized default data on the MSBOS. Additional local configuration of the MSBOS is also displayed.	DR 1,312	Report Tool Upgrade Project Proposal
Audit Trail Report	The Audit Trail Report does not display the Date/Time data was originally saved or the user comment entered for the change. Audit Trail Report entries for Units does not display Unit ABO/Rh at log-in, Expiration date/time, Date/Time received, or the user comment entered for the change.	Low risk/Low impact.	Supervisor reviewing the Audit Trail.	Immediately print the Audit Trail Report for this activity and manually complete the comment and other pertinent details; save it for review.	See the Unit History report for the missing data saved in other options.	CR 2,334	Report Tool Upgrade Project Proposal
Blood Availabili-ty Report	VBECS sorts the Rh neg blood products before Rh pos for an ABO group.	Low risk/Low impact.	All users	None required.	This is a consistent display format. Explanation for system behavior with no user impact.	CR 2,006	Report Tool Upgrade Project Proposal
Blood Availabili-ty Report	"Units with Final Disposition (Not Transfused)" report, defaults a start date of 1/1/1900 and end date of 12/31/9999. Even though the user manually enters new start/end dates, they are not used when the report data is generated.	Low risk/Low impact.	All users	Use the Custom Report option to generate the report.	The time to return the report will be greater if the user accepts the default dates.	CR 2,463	1.6.0.0

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Blood Products	VBECS allows a user to activate a blood product code for a shipper without an associated HCPCS code or text.	Low risk/Low impact.	All users	Add the HCPCS code after the blood product code is activated.	The user can proceed to activate a unit without the code. This may be preferred functionality when the code is unknown so all blood products can be entered without delay for patient availability.	CR 1,217	Maintenance TBD
Blood Products	A system error occurs when the user attempts to change the shipper FDA Registration Number while a warning message is displayed in the Cost or Return Credit fields.	Low risk/Low impact.	All users	Clear the incorrect data entry prior to changing the shipper information.	This information would be updated very infrequently.	CR 1,921	Maintenance TBD
Canned Com-ments	System error occurs when an attempt is made to use Maintain Comments if the user who configures a division in VBECS Administrator is not added to the division as a VBECS user.	Low risk/Low impact.	Administrator	The user that configured the division must be added to the users list in VBECS.	None	CR 2,241	Maintenance TBD
Canned Com-ments	Inactivation of all the canned comments for a category will prevent a user from completing any process that uses these canned comments.	Low risk/Low impact.	Administrator	Do not delete all of the canned comments.	Comments can be recreated by user with appropriate security.	CR 2,243	Maintenance TBD
Compon-ent Classes	VBECS rounds the minutes entered in the maximum transfusion time field to a whole number.	Low risk/Low impact.	Administrator	Check the entry for validity prior to saving.	Explanation for system behavior with no user impact. Transfusion times are reported in minutes.	CR 1,992	Maintenance TBD
Configure Daily QC	Screening Cells vial numbers are not displayed on the Audit Trail Report when there is a configuration change.	Low risk/Low impact.	Administrator	Immediately print the Audit Trail Report for this activity and manually complete the comment; save it for review.	Explanation for system behavior with no user impact. Reagents are updated by set, not individual vials.	CR 1,949	Report Tool Upgrade Project Proposal
Configure Daily QC	The comment details do not display completely on the Audit Trail Report.	Low risk/Low impact.	Administrator	Immediately print the Audit Trail Report for this activity and manually complete the comment; save it for review.	The incompletely displayed comment does not impact patient testing or transfusion records and is an infrequent occurrence.	CR 1,950	Report Tool Upgrade Project Proposal
Configure Daily QC	Reverse ABO cell testing results are not displayed on the Testing Worklist Report. Various reagent lot numbers are not displayed including QC kit, Reverse ABO cells, PEG, LISS, or Anti-Human Globulin.	Low risk/Low impact.	All users performing Daily Reagent QC testing. Supervisor who configures and reviews QC output for compliance	Manually record daily reagent QC testing and reagent lot numbers to remain compliant with regulatory requirements.	The incompletely displayed QC lot numbers and results force the blood bank to establish a policy to record results to maintain a complete record for accreditation and regulatory compliance which has been put in place by the sites. Blood bank staff currently record this manually and have processes and documents to support this activity.	CR 2,385 CR 2,436	1.6.0.0
Configure Daily QC	The OK button on the Configure Daily QC form is enabled even though the user did not change details on the screen.	Low risk/Low impact.	Administrator	None required.	VBECS evaluates that no changes were made and no changes are saved to the database.	CR 1,309	Daily Reagent Quality Control Upgrade

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Configure Daily QC	VBECS Configure QC option will allow a user to configure a reagent rack to use screening cells 1, 2, and 4, instead of 1, 2, and 3 and save.	Low risk/Low impact..	Administrator	Supervisors must verify the configuration to ensure the correct settings are saved.	Evaluation is performed at initial configuration	DR 1,625	Daily Reagent Quality Control Upgrade
Configure Daily QC	VBECS does not permit configuring daily QC to use either Anti-A or Anti-B test with an O Cell	Low risk/Low impact.	Administrator	None required.	Negative control s are available for both antisera. Explanation for system behavior with no user impact.	DR 2,206	Daily Reagent Quality Control Upgrade
Configure Division: Order Alerts	Configure Division/Order Alert setting changes are not included in the Audit Trail Report.	Low risk/Low impact.	Administrator	When changing the order alert setting, document the changes by capturing and saving screen shots.	Access to change settings are restricted by security role.	CR 1,637	Report Tool Upgrade Project Proposal
Cost Account-ing Report	The modification time displays in GMT (system time) on the Cost Accounting Report.	No identified risk/No identified impact	All users can print the report; Supervisor is responsible for its review	Calculate the local time, as required.	None	CR 1,633	Report Tool Upgrade Project Proposal
Cost Account-ing Report	A Reflex ABID test that was entered in error displays on the Cost Accounting Report.	No identified risk/No identified impact	All users can print the report; Supervisor is responsible for its review	None available.	The corrected and entered-in-error entries are included. Extra cost is identifiable on report.	CR 1,994	Report Tool Upgrade Project Proposal
Cost Account-ing Report	If a user places a unit on the outgoing shipment invoice, cancels the invoice, and then places the same unit on another outgoing shipment invoice, VBECS displays a return credit twice on the report.	No identified risk/No identified impact	All users can print the report; Supervisor is responsible for its review	Deselect a unit prior to canceling the invoice to avoid the credit appearing twice on the Cost Accounting Report.	Extra credit is identifiable on report.	CR 1,905	Report Tool Upgrade Project Proposal
Cost Account-ing Report	A unit with an edited return credit in final status will not revert to the original return credit amount when the unit's final status is removed.	No identified risk/No identified impact	All users can print the report; Supervisor is responsible for its review	Select Edit Financial Data and correct the return credit amount.	Extra cost is identifiable on report.	CR 1,871	Report Tool Upgrade Project Proposal
Cost Account-ing Report	The tally of discarded units, waste or credit, may include quarantined units and may not accurately reflect the unit discard as waste vs. credit. When the default credit amount is selected, it appears as $0.00 on the report.	No identified risk/No identified impact	All users can print the report; Supervisor is responsible for its review.	Units listed on the report were quarantined or discarded for the selected date range. Verify the unit and quarantine status of a unit by checking its Unit History Report.	Extra credit is identifiable on report.	CR 2,448	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
CPRS	Inactive and active MSBOS entries are selectable.	No identified risk/Low impact.	All users placing a surgical order in CPRS.	None available.	The facility may choose to remove inactivated MSBOS entries' recommended units. In any case, the provider is free to order any number of units after reviewing the recommendation.	DR 2,821	CPRS v 28 coordinated work.
CPRS	Component orders that are unfilled and expired are not automatically removed from the Active order window.	Low risk/Low impact.	All users	Cancel the unfilled component order in VBECS prior to or at its expiration.	Orders are considered viable and may be used by VBECS.	CR 2,368 DR 2,883	CPRS v 28 coordinated work.
CPRS	CPRS: Orders are not completed in CPRS and Lab when multiple order completion message identifiers are requested within 1/100th of a second of each other.	Very Low risk/Very Low impact.	All users	Discontinue the order in CPRS and cancel the order in Lab.	The completed test results display as expected in CPRS. The likelihood of occurrence of this is rare and should not interfere with normal business practices. This would be very infrequent as multiple users would need to complete orders on the same patient simultaneously.	CR 2,397	CPRS v 28 coordinated work.
CPRS	On the CPRS Blood Bank Report, when an Antibody Screen Test interpretation is "positive" the generic comment for a positive DAT is presented.	No identified risk/Low impact	All CPRS users reading the message associated with the patient's unexpected antibodies.	None available.	Most patients do not have irregular antibodies. When they do, the intent of the message is correct. Contact the blood bank for additional information and expect delayed availability of product for this patient due to the problem. Comment indicates to viewer that additional time may be required to provide future blood components. The message reads: *Preparation of red cell components for transfusion may be delayed due to a positive DAT. Interpret clinical significance of DAT in conjunction with other laboratory test results and clinical evaluation of the patient. Possible causes of positive DAT: delayed transfusion reaction or post-transfusion stimulation of red cell antibody product; warm autoantibodies produced during autoimmune process, drug therapy, or from unknown causes. Contact transfusion service for information on potential clinical significance and availability of red cell components.*	CR 2,435	CPRS v 28 coordinated work.
C:T Ratio Report	Unable to schedule report print time in the future.	No identified risk/No identified impact	All users can print the report, Supervisor is responsible for its review.	None required.	Print report. Administrative report can be printed during the user's session.	CR 2,101	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Discard or Quaran-tine	Cannot edit hour: minutes in Discard Date field	No identified risk/No identified impact	All users	None required.	This option is designed for processing in real time, not retrospective entry. Default is current day/time.	CR 2,074	Maintenance TBD
Discard or Quaran-tine	Cannot designate a Discard/Quarantine Tech ID though the exception report contains both "Test By" and "Override By" columns.	No identified risk/No identified impact	All users	None required.	Discard/Quarantine option does not accommodate the entry of a second user for retrospective entry.	CR 2,076	Maintenance TBD
Discard or Quaran-tine	When a large batch of units is processed, the confirmation window displays with inaccessible buttons prohibiting the user from processing the confirmation.	Low/Low impact	All users	Select no more than 40 units in any batch. If a user finds themselves in this position, they need to X out of the confirmation and re enter the unit tests in smaller runs.	Most VA hospitals are low volume transfusion services and will not receive or process unit confirmation batches exceeding the display area.	CR 2,417	VBECS BCE Interface Project
Display Order Alerts	The tool tip on the Patient Alert icon will not display after VBECS refreshes and no new updates are detected.	No identified risk/No identified impact	Administrator	None required.	User has no new alerts to view so icon function does not prompt the tool tip.	CR 2,168	Maintenance TBD
Division Workload Report	The Division Workload Report will not print as “Preliminary” when the report contains the current day in the range of data requested.	No identified risk/ No identified impact	All users	None available.	Users are cautioned to pay attention to the date range of this report. Workload is an administrative report that is not required the day the data is created.	CR 2,148	Report Tool Upgrade Project Proposal
Document ABO Incompat-ible Transfus-ions	VBECS does not display qualified units when a Received Date (before) and Received Date (after) search criteria are used to select a unit in this option.	Very Low risk/ Very Low impact.	Administrator	None required.	Do not use the received date search criteria to create a pick list of unit records for selection. This is a very low frequency event and the user would attempt to locate the unit with this type of search.	CR 2,456	Maintenance TBD
Edit Financial Data	When a unit is “transferred,” VBECS does not enable the Return Credit field in the Edit Unit Financial Data window.	Low risk/Low impact.	All users	Process the unit through Remove Final Status, adjust the return credit amount, and reprocess the outgoing shipment information.	Return credit is set up as a default value so this would only be used for a rare return outside of the vendor contract amount.	CR 1,777	Maintenance TBD
Edit Financial Data	When a Technologist enters a unit ID and product code for a unit that is not in final status, VBECS does not enable the Special Test Cost field.	No identified risk/ No identified impact	Technologist only	An Enhanced Technologist or higher access can change the Special Test Cost field in the Edit Financial Data option.	None	CR 1,819	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Edit Financial Data	Entry of a hyphen (-) or a comma (,) in any of the three editable numeric fields generates an error message: "Value entered is not a valid number."	No identified risk/No identified impact	All users	None required.	None	CR 1,890	Maintenance TBD
Edit Unit Informa-tion	When Inactivating a unit the incorrect list of canned comments is presented. The list of comments shown corresponds to the canned comment category "Unit Status Removal" instead of "Unit Inactivation".	Low risk/Low impact.	Supervisor	Enter comments selectable during "unit inactivation" in the Canned Comment Category of "Unit Status Removal".	Canned comments are site configurable to include desired comments. "Other" and a free text comment is also available.	CR 2,270	Maintenance TBD
Edit Unit Informa-tion	A split unit and associated units may be restricted to and transfused to different patients.	No identified risk/No identified impact	Supervisor reviewing transfusion records	None required.	This may be the desired functionality.	DR 2,218	Maintenance TBD
Edit Unit Informa-tion	In the unit volume field, numeric values outside the allowed range can be entered. VBECS changes the entry to an acceptable value without a warning message.	No identified risk/No identified impact	Supervisor	Check the entry for validity prior to confirming the save. Edit as required.	None	CR 1,917	Maintenance TBD
Edit Unit Informa-tion	When two ABO/Rh confirmation tests are present and both require invalidation, VBECS does not allow both tests to be invalidated in the same transaction.	No identified risk/No identified impact	All users	Perform one invalidation action at a time. Invalidate one test, leave the option, and go back to invalidate the second test.	This may be the desired functionality.	CR 1,906	Maintenance TBD
Edit Unit Informa-tion	Inactivating the parts of a split units will result in negative workload equal to the number of splits created applied to the total number of units logged in.	No identified risk/Low impact	Supervisor	None available.	Infrequent user action that only affects laboratory workload reports.	CR 2,224	Maintenance TBD
Edit Unit Informa-tion	The "Biohazardous?" checkbox can be cleared for Donation Type: For Autologous Use Only, Biohazardous, but the donation type of the unit is not editable. If the unit is re-edited, the checkbox displays as re-checked and disabled. The Unit History Report indicates this field is cleared.	Low risk/Low impact.	All users	When an autologous unit is considered biohazardous because the testing results are incomplete and expected, select the donation type "For Autologous Use Only" and select incomplete disease marker testing which sets the biohazardous indicator. The biohazardous indicator and disease status are editable when testing results are received.	Select the donation type "For Autologous Use Only, Biohazardous" only when the unit testing is not pending	CR 2,262	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Edit Unit Informa-tion	When attempting to edit a unit in a final status, VBECS displays the wrong message “Blood Unit not found for Unit Id/Product Code” .	No identified risk/ No identified impact.	All users	None required. VBECS does not allow edit of the unit, which is correct.	None	CR 2,310	Maintenance TBD
Edit Unit Informa-tion	"Entered in Error" displays when a unit antigen typing test is invalidated instead of "Test Invalidated".	No identified risk/ No identified impact.	All users	None required.	Comment is associated with the usual reason for invalidation. Test result is effectively invalidated. The text is essentially equivalent and not confusing the blood bank user.	CR 2,330	Maintenance TBD
Edit Unit Informa-tion	The OK button is enabled unnecessarily.	No identified risk/ No identified impact.	All users	None required.	VBECS evaluates that no changes were made and no changes are saved to the database.	CR 2,359	Maintenance TBD
Enter Daily QC Results	A VBECS system error occurs when a user maximizes the reagent rack selection window while performing QC on the rack.	No identified risk/ Low impact.	All users	Do not maximize the reagent rack window.	User may need to reenter unsaved QC data. Full screen display is not required to view the test grid. The window is set to display in a size that does not lead to this problem. The user must maximize the window purposefully to create this error. Generally this happens to one user during validation and is mitigated by training.	CR 1,911	Daily Reagent Quality Control Upgrade
Enter Daily QC Results	The user cannot save a partially filled worksheet due to inactivity timeout.	No identified risk/ No identified impact.	All users	The user must maintain activity on their screen/session to prevent the activity timeout, and then the lock on the worksheet will not expire.	Unsaved data must be reentered if the locally configured timeout is exceeded.	CR 2,131	Daily Reagent Quality Control Upgrade
Enter Daily QC Results	Rack Daily QC cannot be saved if one of the QC’d racks was partially QC’d.	No identified risk/ No identified impact.	All users	Perform QC for only one rack at a time or for multiple racks to segregate non-QC’d racks from partially completed racks.	This is a rare issue since normal workflow is to complete all QC testing together or to have each user perform own QC.	CR 2,145	Daily Reagent Quality Control Upgrade
Enter Daily QC Results	If a partially tested rack is designated as not tested for a given day, VBECS displays the reagent rack on both the Partially Tested and Not Tested tabs.	No identified risk/ No identified impact. .	All users	None required.	None.	CR 1,761 CR 1,918	Daily Reagent Quality Control Upgrade

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Enter Daily QC Results	Twenty-four-hour expiration messages are displayed more frequently than required.	No identified risk/ No identified impact.	All users	Acknowledge the expired reagent-warning message and continue.	Explanation of VBECS behavior. User requirements need further definition.	CR 1,768	Daily Reagent Quality Control Upgrade
Enter Daily QC Results	When a user clicks No on the decision box to not use a reagent/antiserum that is within 24 hours of expiration (23:59 on the expiration date), VBECS moves the cursor to the next reagent lot number field and *does not* remove the lot number of the previous cell.	No identified risk/ No identified impact.	All users	Change the lot number of the reagent or continue using it until the actual expiration date and time.	Explanation of VBECS behavior. User requirements need further definition.	CR 1,861	Daily Reagent Quality Control Upgrade
Enter Daily QC Results	VBECS antiglobulin testing grids for QC have a title of IAT. The same grid for patient testing is titled AHG.	No identified risk/ No identified impact.	All users	None required.	IAT and AHG are synonyms for the antiglobulin testing and is not a patient safety concern.	DR 1,230	Daily Reagent Quality Control Upgrade
Enter Daily QC Results	PS AHG always appears on the lot number page though it is may not be used.	No identified risk/Low impact.	All users in full service divisions.	Enter the Lot number of the specific AHG used for antibody screen QC. Note in the procedure that the lot number is accurate for the reagent used in QC and testing.	Explanation of VBECS behavior.	DR 2,679	Daily Reagent Quality Control Upgrade
Enter Daily QC Results	Line items may display in a different order on a display and report after a change to the configuration.	No identified risk/ Low impact.	All users in full service divisions.	None required.	Explanation of VBECS behavior. Re organization of the same line items.	CR 2,437	Daily Reagent Quality Control Upgrade
Enter Reflex Test Results	The facilities pick list is not restricted to those marked as testing facilities.	No identified risk/ No identified impact.	All users	None required.	Explanation of VBECS behavior.	DR 1,651	Maintenance TBD
Equip-ment	The equipment type does not print on the report; column information may be truncated; if the manufacturer city is not entered, the state and zip code do not print.	No identified risk/ No identified impact.	All users when equipment maintenance records are defined in VBECS.	None required.	Report data may be reviewed on screen. This is optional data entry for a site. They may have an existing equipment process that they prefer and do not use the VBECS option to record periodic maintenance.	CR 2,036	Report Tool Upgrade Project Proposal
Exception Report	"Visual Inspection Information" and the selected processing "User Information" are not included in Exception Report entry.	No identified risk/ No identified impact.	All users	See the Unit History report, Issue/Return section for the "Visual Inspection Information" as an entry detail for Transaction Type: Unit unsatisfactory upon return from issue.	None	DR 2,479	Report Tool Upgrade Project Proposal

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Exception Report	When invalidating results from Unit Antigen Typing the Exception Report does not show all invalidated values.	No identified risk/ No identified impact.	All users	View the invalidated tests on the Testing Worklist Report and the Unit History Report.	None	CR 2,022	Report Tool Upgrade Project Proposal
Exception Report	Exception Report does not work with the report scheduler.	No identified risk/ No identified impact.	All Users	Users must run the report when needed.	This report is printed regularly and reviewed for daily work so system performance is not impacted.	CR 2,257	Report Tool Upgrade Project Proposal
Exception Report	The “Expired reagent QC’d” exception type section does not include the rack identification or the phase.	No identified risk/ No identified impact.	All users	The lot numbers and testing phases associated with the DAT testing are included in the Testing Worklist Report in the Miscellaneous testing and QC sections, respectively, of the report. The rack identifier and/or phase may be manually added to the Exception Report prior to or during the review.	None	CR 1,626 CR 1,636	Report Tool Upgrade Project Proposal
Exception Report	The date and time displayed on the report are the date and time the override’s OK button was clicked.	No identified risk/ No identified impact.	All users	The difference in the save and the override times is recorded in the same section of the report.	None	CR 1,897	Report Tool Upgrade Project Proposal
Exception Report	Not all exception types use the date and time of the save as the date and time of the exception.	No identified risk/ No identified impact.	All users	None available.	None	CR 2,055	Report Tool Upgrade Project Proposal
Exception Report	The previously recorded Results Inactivated exception type is not generated when a crossmatch is inactivated by Invalidate Test Results or by using the red X in the grid.	No identified risk/ No identified impact.	All users	None available.	The Testing Worklist Report contains the details of the invalidated testing and is recommended for daily supervisory review with the Exception Report. Infrequent event that is performed by a user with higher security role if the blood product was issued.	CR 2,035	Report Tool Upgrade Project Proposal
Exception Report	The User ID is displayed in the Tested By column (instead of User Name) for exception type: Expired Task Processed.	No identified risk/ No identified impact.	All users	None required.	None	CR 2,106	Report Tool Upgrade Project Proposal

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Exception Report	Modification exceptions do not display full (eight-digit) product codes for ISBT 128 labeled units. The sixth, seventh, and eighth digits are not included.	No identified risk/ No identified impact.	All users	None available.	Obtain the full ISBT 128 product code from the Unit History Report, as necessary. Format is understandable to users.	CR 1,995	Report Tool Upgrade Project Proposal
Exception Report	If patient ABO/Rh results are not entered in the order of performance (current testing is entered before the retrospective data entry), the Exception Report entries for an ABO/Rh interpretation discrepancy are displayed based on the time the data are entered (the OK button is clicked).	No identified risk/ No identified impact.	All users	None available.	The correct blood type system rules are applied. The report columns state Current/Previous, the individual exceptions include the date/time of entry allows the sequencing of testing.	CR 2,048	Report Tool Upgrade Project Proposal
Exception Report	Exception Report and Blood Unit History Report display the testing status code from the database in the "Testing Status" section for autologous units.	No identified risk/ No identified impact.	All users	None required.	The values displayed in “Testing Status” translate to: 1 - NEG - Unit fully tested and negative for all disease markers.2 - POS - Unit tested and positive for one or more disease markers, Biohazard. 3 - NFT - Unit not fully tested for one or more disease markers, Biohazard.	CR 2,118	Report Tool Upgrade Project Proposal
Exception Report	The user ID of the issuing user appears on the report instead of the user name.	No identified risk/ No identified impact.	All users	None available.	None	CR 2,201	Report Tool Upgrade Project Proposal
Exception Report	VBECS Exception Report does not display a patient’s first name for Unacceptable/Expired Specimen Used exceptions.	No identified risk/ No identified impact.	All users	None required.	Patient ID and specimen UID are presented in full with patient last name allowing further investigation of the exception as required.	CR 2,309	Report Tool Upgrade Project Proposal
Exception Report	VBECS displays ISBT unit ID and product short name, but not the product code.	No identified risk/ No identified impact.	All users	None available.	See the Unit History report for the missing data saved in other options.	DR 2,323	Report Tool Upgrade Project Proposal
Finalize/ Print TRW	VBECS only displays 350 characters entered into the transfusion reaction details field on the finalized transfusion reaction report.	No identified risk/ No identified impact.	Supervisor	Full text can be seen on the Transfusion Reaction Count Report (Detailed).	Report is printed for medical director signature and charting. Printed report can be updated manually if required or by using a VistA consult.	CR 2,230	1.6.0.0

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Finalize/ Print TRW	A finalized Transfusion Reaction Workup cannot be corrected once it has been finalized.	No identified risk/ No identified impact.	Supervisor	None available.	Users are cautioned to double check the workup before finalizing. Report is printed for medical director signature and charting. Printed report can be updated manually if required.	DR 1,633	1.6.0.0
Finalize/ Print TRW	The Transfusion Reaction Report does not display all of the patient's transfusion reactions in different divisions on a single page.	No identified risk/ No identified impact.	Supervisor	The report shows patient records by the division.	All patient results are available on a single report and are easily viewable.	DR 2,681	Report Tool Upgrade Project Proposal
Finalize/ Print TRW	When finalizing a TRW report and VistaLink is down, a pop up message that VistaLink is down and the DSS message cannot be sent displays. VBECS should resend it later. However, the message is not resent.	Low risk/Low impact.	Supervisor	None available.	TRW finalization happens infrequently; VistAlink downtime also happens infrequently. This does not impact patient test reporting.	CR 2,455	1.6.0.0
Free Directed Unit For Cross-over	VBECS displays the logged on user performing the Free Directed Units for Crossover process even if he selects a different user name in the Removed By field.	Low risk/Low impact.	Enhanced Tech	Do not use Free Directed Units for Crossover during downtime.	When processed in downtime, the selected user is recorded on the downtime form.	CR 1,853	Maintenance TBD
Free Directed Unit For Cross-over	A duplicate unit record may be created when an ISBT 128 unit is entered with a donation type of "D" and changed to a donation type of "V" during Free Directed Unit option and the unit was also entered during Incoming Shipment with the donation type "V".	Low risk/Low impact.	All users	When a unit is received from the blood supplier with a donation type of "V" and the unit is to be restricted to a patient as a directed donation, the product code must be manually entered with a "D" to allow the restriction in a Full Service Blood Bank. A Transfusion Only facility type will not encounter this problem as the option Free Directed Unit is not enabled.	If the user tried to bring the unit into inventory using both methods, the incorrect unit can be invalidated to prevent the duplicate record. The unit label would reflect the correct unit status per local policy.	CR 2,261 DR 2,735	Maintenance TBD
Free Directed Unit For Cross-over	The "Unit is in a final status" VBECS message is missing the "a."	Low risk/Low impact.	Enhanced Tech	None required.	None	CR 1,448	Maintenance TBD
Incoming Shipment	VBECS does not use a blood unit's collection facility FDA number to determine uniqueness of a Codabar labeled blood product. Units that are numerically duplicate, not counting the two-digit eye readable prefix and alpha characters, will be considered duplicate.	No identified risk/ Low impact.	All users	Units that are identified as duplicate and having been in VBECS must be returned to the blood supplier.	This is a historical problem with Codabar labeling that will only be rectified with the adoption of ISBT 128.	DR 2,536	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Incoming Shipment	When an invalid barcode is scanned into the Unit ID field, the user is not alerted. An invalid Codabar unit ID may display: "System.Runtime.InteropServices.SEHException ."	Low risk/Low impact.	All users	The entry is not accepted or displayed. Reenter the unit ID information.	The message does not explain the problem but the user can easily see that the scanned field did not properly display. The user cannot proceed until corrected.	CR 1,212 CR 1,536	Maintenance TBD
Incoming Shipment	When the user holds the mouse over the disabled OK button; VBECS displays the tool tip associated with the OK, instead of the tool tip that prevents the activation.	No identified risk/ No identified impact.	All users	Check the tool tips for the active field and OK button. If there is a conflict, comply with the field error message.	None	CR 1,721	Maintenance TBD
Incoming Shipment	When a user enters a valid date in the Expiration Date field and tabs out of the field, the save button is enabled. If the user returns to the expiration date, clicks the Delete or Backspace key to delete it, and tabs out of the field, the button remains enabled and the previously entered date and time are saved.	Low risk/Low impact.	All users	Inactivate and reenter the unit to correct the entry.	User is allowed to correct the date before save which would be the usual reason for revisiting the field. The date is presented for review before the user finally accepts.	CR 1,605	Maintenance TBD
Incoming Shipment	When an ISBT 128 labeled unit is manually entered without a full product code (donation type or aliquot digits are not entered); VBECS assigns the default donation type of "voluntary allogeneic" and does not allow selection of the unit for pooling, if available.	Low risk/Low impact.	All users	Scan an ISBT 128 product code; do not manually enter the product code: the donation type code and aliquot digits are required. The unit may be invalidated and reentered if the donation type was incorrectly accepted.	VBECS assignment is based on the information entered. Information displays for user review so user is unlikely to accept unit. Also, this option has is marked for audit if barcode scanning is not used to assist sites in enforcing scanning to decrease errors.	CR 1,610	Maintenance TBD
Incoming Shipment	A VBECS system error occurs if a user attempts to continue entering a unit after canceling out of an opened and required Maintain Blood Products window.	No identified risk/ No identified impact. .	All users	After canceling out of Maintain Blood Products, click the Clear button in Incoming Shipment to clear the previous unsaved unit entry before rescanning.	None	CR 1,895	Maintenance TBD
Incoming Shipment	Only the first six characters of a non-scanned ISBT 128 product code are displayed on the mock blood bag label. The aliquot codes are not displayed.	No identified risk/ No identified impact.	All users	None required.	Full product information displays in the view.	CR 1,591	Maintenance TBD
Incoming Shipment	The Restricted For Patient field may be difficult to read: the text is gray on a gray background.	No identified risk/ No identified impact.	All users	None required.	The correct information is displayed. Patient information displays without gray background in other options.	CR 1,719	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Incoming Shipment	Two messages that may be displayed when opening an invoice may be ambiguous: 1) “Do you want to create a new invoice and add units to it?” 2) “Attempting to enter an expired unit. Do not proceed if you are retrospectively entering a shipment during VBECS downtime. Enter the actual date and time the shipment was received. Proceed?”	No identified risk/ Low impact.	All users	None available.	1) This is a confirmation message to start a new invoice. 2) This is a confirmation message to enter an expired unit into inventory. Online Help provides additional information if user is unclear about the questions.	CR 1,935	Maintenance TBD
Incoming Shipment	The Unit History Report will not show a unit that has been in inventory as CMV negative, shipped out, and then received again through Incoming Shipment as CMV negative.	No identified risk/ Low impact.	All users	None available.	VBECS still holds the CMV negative indicator and treats the unit as CMV negative. User is expected to reenter the CMV test during unit receipt.	CR 1,932	Report Tool Upgrade Project Proposal
Incoming Shipment	The Unit History report displays results of Antigen Typing on a unit when the additional daily QC rows (POS and NEG) are processed the testing row is displayed three times.	No identified risk/ No identified impact.	All users	Select the one labeled for the Antisera as the result, or look at the Testing Worklist Report.	QC results are also displayed but easily distinguishable from unit testing.	CR 2,181	Report Tool Upgrade Project Proposal
Incoming Shipment	Units that are received with product codes containing the quarantine unit attribute are not automatically quarantined by VBECS.	Low risk/Very Low impact.	All users when a quarantined unit is received.	Each site must evaluate risk if they receive quarantined units from their blood supplier.	The unit display name includes “QUAR” which will alert the user regarding this units attribute. This was designed to force user evaluation.	DR 1,322	Maintenance TBD
Incoming Shipment	When entering a response of “YES” to the message that you are attempting to re-enter a unit, a pop up appears “System Error: Unit already exists in the division.” Click OK and the expected message about “Are you sure you want to add this unit?” displays and allows the user to proceed normally.	No identified risk/ Low impact	All users where it is not common practice to move blood products in and out of inventory.	None required.	This may occur when a unit is returned to the supplier and then back to the facility for use. User is allowed to proceed with the unit entry. If this is common practice related to inventory maintenance, the user would not have any impact.	CR 2,401	Maintenance TBD
Incoming Shipment	Online help does not include the limitation: “The display label that is built when logging a blood product into VBECS does not change from volunteer donor to autologous when the donation type is changed.”	No identified risk/ No identified impact.	All users	None required.	User manual includes explanation but online help was not updated. The label display is provided as an additional visual and is not used in unit verification.	CR 2,466	1.5.0.0
Incoming Shipment	When a Local Facility is activated during entry of a Codabar blood unit, the facility is set to the default of no prefix or alpha characters in the unit id.	No identified risk/ Low impact.	All users	None required.	Enter the prefix and indicate alpha characters as appropriate using the Local Facilities option. Format is understandable to users. The addition of facility specific information is a standard requirement.	CR 2,459	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Incoming Shipment	Codabar product codes 03320, 03330, 03380, and 03390 associated with the product type E009 (Apheresis Red Blood Cells), do not have a maximum expiration date of 672 hours (28 days). The maximum expiration date is set to 1008 hours (42 days) on the blood product table.	Low risk/No identified impact.	None when they use the system calculated expiration date in modification or enter the expiration date as indicated on the blood unit at Incoming Shipment both are standard of practice.	Enter the expiration date and time of the unit received as labeled. When presented as a target component, accept the expiration date/time as calculated by VBECS.	The unit expiration is handled so no unit has an extended expiration date assigned.	DR 3,098	1.5.0.0
Incoming Shipment	Codabar product codes 27286 and 27287 associated with the product type E002 (Red Blood Cells), do not have a maximum expiration date of 672 hours (28 days). The maximum expiration date is set to 1008 hours (42 days) on the blood product table.	Low risk/No identified impact.	None when they use the system calculated expiration date in modification or enter the expiration date as indicated on the blood unit at Incoming Shipment both are standard of practice.	Enter the expiration date and time of the unit received as labeled. When presented as a target component, accept the expiration date/time as calculated by VBECS.	The unit expiration is handled so no unit has an extended expiration date assigned.	DR 3,098	1.5.0.0
Incoming Shipment	Codabar product code 18161 associated with the product type E010 (PLASMA FROZEN WITHIN 24 HOURS AFTER PHLEBOTOMY IRRADITATED), does not have a maximum expiration date of 8760 hours (365 days). The maximum expiration date is set to 672 hours (28 days) on the blood product table.	Low risk/No identified impact.	None when they use the system calculated expiration date in modification or enter the expiration date as indicated on the blood unit at Incoming Shipment both are standard of practice.	Enter a 28 day expiration at incoming shipment. If the unit is unused in inventory on the 27th day and does not expire; ship out and re-enter the unit into inventory for another 28 days.	The unit expiration is handled so no unit has an extended expiration date assigned.	DR 3,098	1.5.0.0

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Incoming Shipment	Codabar product codes 05050, 05051, 05055, 05350, 05351, 05355, 34051, 34052, 34053, 34054, 34055, 34056, 34057, and 34058 associated with the product type E002 (Red Blood Cells), do not have a maximum expiration date of 504 hours (21 days). The maximum expiration date is set to 672 hours (28 days) on the blood product table.	Low risk/No identified impact.	None when they use the system calculated expiration date in modification or enter the expiration date as indicated on the blood unit at Incoming Shipment both are standard of practice.	Enter the expiration date and time of the unit received as labeled. When presented as a target component, accept the expiration date/time as calculated by VBECS.	The unit expiration is handled so no unit has an extended expiration date assigned.	DR 3,098	1.5.0.0
Invalidate Test Results	A VBECS system error occurs when a user attempts to invalidate two crossmatch results and the blood unit was assigned, crossmatched, released, reassigned, and crossmatched again on the same specimen.	No identified risk/Low impact.	All users	Invalidate the first crossmatch save and exit the invalidate Patient Results option. Reenter the Invalidate Patient Results option to invalidate the second crossmatch.	Requires security role to complete and would be performed administratively.	CR 1,925	Testing Grids
Invalidate Test Results	When an antigen typing is invalidated; VBECS selects the Pending Task List check box. If the user does not clear the box, the test is automatically put back on the Pending Task List.	No identified risk/ No identified impact.	All users	Cancel the test on the Pending Task List, as necessary.	The user would be prompted to return to option by the test reappearance.	CR 1,596	Testing Grids
Invalidate Test Results	VBECS does not display the implicated unit product code for a transfusion reaction workup in the Invalidate Patient Test Results option.	No identified risk/ No identified impact.	All users	None required.	The option displays the product short name, which is materially equivalent to the product code.	CR 2,026	Testing Grids
Invalidate Test Results	"The patient has history of justified ABO/Rh change" warning message contains an extra space.	No identified risk/ No identified impact.	All users	None required.	None	CR 1,597	Testing Grids
Invalidate Test Results	A system error occurs when attempting to invalidate a crossmatch test after the unit has been marked unsatisfactory for issue in Issue Unit.	No identified risk/No identified impact.	All users	If the unit is unsatisfactory for issue because the crossmatch test is incorrect, do not mark the unit unsatisfactory, release the unit from assignment and invalidate crossmatch test.	The steps follow user expectations but the error message should inform the user to use another process. This is an administrative process with security role.	DR 3,046	Testing Grids

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Issue Blood Compo-nents	A system error occurs when a user attempts to issue a unit assigned or crossmatched to a patient with an expired specimen.	No identified risk/Low impact.	All users except Supervisor who is allowed to proceed with override.	Go to Orders, Maintain Specimen, change the specimen expiration date so it is not expired and issue the unit. This may require a temporary change of the Maximum Specimen Expiration Date in the Configure Division option.	The steps follow user expectations but the error message should inform the user to use another process. This is an administrative process with security role.	CR 2,092	Select Unit Project Proposal
Issue Blood Compo-nents	When the user clicks Cancel, VBECS closes without displaying a confirmation message that data are lost.	No identified risk/Low impact.	All users	If canceled in error, recreate the data.	The steps follow user expectations to reduce the number of user responses.	CR 1,598	Select Unit Project Proposal
Issue Blood Compo-nents	Plasma can be issued frozen without thawing when associated with the order type is "OTHER."	No identified risk/Low impact.	All users	"OTHER" products require special consideration by local policy.	Most Plasma product codes are processed in an FFP order not in the OTHER orderable. “OTHER” products are handled with local policies as described in the User Guide section.	CR 2,254	Type III Blood Product Table Update
Issue Blood Compo-nents	Missing a space between the sentences: “This unit had a crossmatch result of incompatible or the crossmatch was not completed. This unit cannot be issued.”	No identified risk/ No identified impact.	None	None required.	Format is understandable to users.	CR 2,085	Maintenance TBD
Issue Blood Compo-nents	Due to an unjustified discrepant ABO, the assigned O negative units appear on the Emergency Issue tab, not the assigned tab, without an information message to explain why.	No identified risk/ No identified impact.	None	None required.	The unit may be issued. The unit may meet crossmatch requirements but VBECS still invokes Emergency Issues rules since other testing criteria have not been met.	CR 1,794	Select Unit Project Proposal
Issue Blood Compo-nents	When retrospective data is entered into VBECS after a more recent specimen test result, the blood type of the retrospective entry is compared to the most recent test result.	Low risk/Low impact.	All users when entering retrospective testing out of chronologic order of execution.	None required.	Enter retrospective testing in chronological order so the current specimen is the last test entry for the patient. Any testing discrepancy requires supervisor review and action.	CR 2,011	Select Unit Project Proposal
Issue Blood Compo-nents	VBECS may display an inactivated unit in the unit search screen without any indication of its inactivated record status.	No identified risk/ No identified impact.	All users when inactivated unit records are available in the division.	None required.	The best practice for issue is to scan the unit information. The unit relocation cannot proceed if an inactivated unit is selected off the list. Users are directed by User Guide and local policy to use the unit for selection.	CR 1,877	Select Unit Project Proposal
Issue Blood Compo-nents	When VBECS opens the Issue Blood Components window the focus (cursor) is not in the unit ID field.	No identified risk/ No identified impact.	All users	A user must first click in the Unit ID field to bring the focus to that field before scanning or entering a unit number.	No errors are expected to result.	CR 2,129	Select Unit Project Proposal

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Issue Blood Compo-nents	When VBECS warns that a unit is assigned to another patient; the user is prompted to process an override and enter a comment to proceed.	Low risk/Low impact. The comment can be viewed with the historical record.	All users	Complete the override to proceed.	The entered comment is not recorded or displayed on the Exception Report.	CR 1,798	Select Unit Project Proposal
Issue Blood Compo-nents	The message displayed reads "Original and repeat ABO/Rh interpretation do not match." The 2nd sentence in the designed message "You must resolve the discrepancy before units can be issued." is not displayed.	Low risk/Low impact.	All users	None required.	VBECS will not allow the user to proceed with specimen processing until the discrepancy is resolved thus mitigating the hazard.	CR 2,203	Select Unit Project Proposal
Issue Blood Compo-nents	The workload recorded for Issue Units is doubled on the VBECS Workload Report.	Low risk/Low impact.	All users	None required.	VistA workload is correct. Workload validation clarification.	CR 2,242	VBECS BCE Interface Project
Issue Blood Compo-nents	Surgical initiative status is sent as assigned not compatible or issued.	Low risk/Low impact.	All users	None required.	The unit is available for bedside verification to the surgical initiative only after the unit has been physically issued from the blood bank regardless of the unit status in VBECS. Unit is correctly handled between VBECS and Surgery so only units that are issued by VBECS are transfused.	CR 2,333	Maintenance TBD
Issue Blood Compo-nents	Blood is issued to the VistA Hospital location associated with the VBECS division, not a VistA hospital location associated with a mapped associated VistA Institution hospital location in VBECS Administrator.	Low risk/Low impact.	All users	None required.	Optionally, use the remote storage location to add details of exactly where the products for transfusion were delivered to at the remote site. Clarification of design to allow more details as to transfusion locations.	DR 2,881	Select Unit Project Proposal
Issued/ Returned Units Report	The date and time of unit return is not included on this report if it is different from the time the returned unit is selected (retrospective entry) at the time of data entry. The report does not include issue and return comments, as expected.	Low risk/Low impact.	All users	None available.	The report does not include the selected date/ time or processing date/ time fields. This information is displayed on the Unit History Report in the Issue Information section. Comment fields are not available at the time of issue or return, so none are available for the report.	CR 2,044	Report Tool Upgrade Project Proposal
Issued/ Returned Units Report	If a unit is entered into Incoming Shipment as one product code and then issued, and after issue modified to a new product code, the Issued/Returned Units Report will not show the original product code. Only the new modified product code displays.	Low risk/Low impact.	All users	A user can determine the original product by viewing the Unit History Report.	This is performed by a user with proper security role.	CR 2,185	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Issued/ Returned Units Report	The Issue/Returned Report does not display the processing user and time of entry when results are entered retrospectively.	Low risk/Low impact.	All users	None required.	Retrospective data entry has supporting downtime documentation to capture the user information.	DR 2,072	Report Tool Upgrade Project Proposal
Justify ABO/Rh Change	When a database conversion blood type is one of the two blood type results involved in a justification, the database conversion blood type does not display on the Audit Trail Report entry of the justification.	Low risk/Low impact.	Administrator	None required.	The information is available on the Patient Record Report. Details are readily available to the reviewer.	CR 1,913	Report Tool Upgrade Project Proposal
Justify ABO/Rh Change	When initially displayed, the VBECS patient name field in the Justify ABO/Rh Change option may not display the expanded field.	Low risk/Low impact.	Administrator	Maximize the window to display the expanded (full name) field for long patient names.	Details are readily available to the user.	CR 1,914	Maintenance TBD
Log Into VBECS and VistA	A cancelled VistA Logon - Authorization window at initial sign-on reopens automatically several times before staying closed.	Low risk/Low impact.	All users	None available.	None	CR 1,837	Maintenance TBD
Log Into VBECS and VistA	System error occurs when a user tries to log in and their role has been inactivated in that division instead of presenting the message "Your role within the division <Name> was inactivated. Please contact your system administrator."	Low risk/Low impact.	All users	None required.	The user is not able to access the division.	CR 2,361	Maintenance TBD
Maintain Minimum Levels	The minimum stock level for the reagents field allows the entry of a decimal that causes the reversal of the entry (e.g., user entry of “1.5” becomes “51”) and may be saved.	Low risk/Low impact.	Administrator	Enter whole numbers; do not enter decimals. Check the accuracy of the entry before saving.	There is no location to allow decimal entries but may occur through misuse of the option. Entries are not tied to patient testing and are used for reagent maintenance.	CR 1,686	Daily Reagent Quality Control Upgrade
Maintain Minimum Levels	Update reagents shows different information for a lot number than the Reagent Inventory report. The Reagent Inventory report displays each individual entry but the update reagent lot number view displays only the last entry for the lot number.	Low risk/Low impact.	Administrator	Enter with * at the beginning and end of the lot number. User may also re-enter lot number if changing the invoice number. See the Reagent Inventory Report.	The report displays all changes in full.	CR 2,209	Daily Reagent Quality Control Upgrade
Maintain Minimum Levels	In a multidivisional environment, the reagent report for a division will print one line item for each division that has set minimum levels for that reagent type. For example, if you have minimum levels for Reagent A, and two other divisions have minimum levels for Reagent A, that reagent information will print three times on your report.	No identified risk/ No identified impact	Administrator	There is no crossover of data, and no safety issue. If minimum levels are not set in a division, then it will not factor into the display. In a single-division environment, there is no such problem.	The report accurately displays the inventory at each division.	CR 2,233	1.6.0.0

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Maintain Specimen	A VBECS system error occurs when a user allows two consecutive system timeouts.	Low risk/Low impact.	All users	Once in the option, perform specimen processing immediately.	This occurs when the user repeatedly enters the option and does not complete the window.	CR 875	Testing Grids Project Proposal
Maintain Specimen	For a component order that does not require a specimen, VBECS calculates the order's expiration date and time to the "minute" from the collection time, not the appropriate day with an expiration time of 23:59.	Low risk/Low impact.	All users	Request a new component order, as needed.	VBECs expires the order at the time of day 10 days after the order was accepted. The order is simply expired hours earlier on the 10th day.	CR 1,930	Testing Grids Project Proposal
Maintain Specimen	When a specimen expiration is more than 72 hours in the future and a blood product is issued, the specimen expiration is recalculated to 72 hours from the time of issue.	Low risk/Low impact.	All users	None required.	The expiration date is recalculated at blood product issue to expire hours earlier on the 3rd day when it would normally expire.	CR 2,485	Testing Grids Project Proposal
Medica-tion Profile	A Crystal Reports Forms Viewer Error may appear: "Query Engine Error."	Low risk/Low impact.	All users	None available. Reenter the report search.	Use the patient tool bar link to the medication profile report to avoid this error.	CR 1,560	Report Tool Upgrade Project Proposal
Medica-tion Profile	VBECS does not display the "No medications were found for the date range" message when the report does not return data.	Low risk/Low impact.	All users	None required.	A blank report is displayed showing the date range and "End of Report." Business processes and patient safety are not impacted; display of the blank report is inconsistent with report messaging. This is a presentation inconsistency.	CR 1,577	Report Tool Upgrade Project Proposal
Modify Units (not Pool or Split)	The Volume Reduce Unit form contains fields for discarded plasma volume and original unit volume. When either field contains data entry errors, the OK button is enabled, which allows the user to save the form.	Low risk/Low impact.	All users	None available. Check the accuracy of the entry before saving.	The volumes are saved as entered, The volume total may not match the original default volume.	CR 1,924	Type III Blood Product Table Update
Modify Units (not Pool or Split)	When a user enters a value outside the allowable range in the Target Unit Volume field; VBECS accepts the entry but disables the OK button.	Low risk/Low impact.	All users	Correct the entry within the acceptable volume range to enable the OK button and save the modification.	Tool tip on the OK button directs the user to correct their entry.	CR 1,920	Type III Blood Product Table Update
Modify Units (not Pool or Split)	VBECS truncates the product name.	No identified risk/No identified impact.	All users	View the Unit History Report header.	The full product name is not normally required for modification and is not required by a user already in the modification process.	CR 1,698	Type III Blood Product Table Update

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Modify Units (not Pool or Split)	VBECS does not allow volume reduction of Deglycerolized RED BLOOD CELLS, Deglycerolized Rejuvenated RED BLOOD CELLS, Deglycerolized APHERESIS RED BLOOD CELLS Rejuvenated Apheresis RED BLOOD CELLS and Deglycerolized Rejuvenated Apheresis RED BLOOD CELLS: no target products are available.	No identified risk/No identified impact	All users	The user can go to Edit Unit Information and change the volume of the product. They cannot indicate a discarded volume.	Volume reduction of a deglycerolized product is not performed as the cells are packed in minimum amounts of fluid per the deglycerolization process.	DR 1,632 DR 1,942	Type III Blood Product Table Update
Modify Units (not Pool or Split)	A blood component that ships into VBECS with an attribute of (Quarantine) is modifiable in VBECS because it does not have any record of having been quarantined in the Discard/Quarantine function within VBECS. Units that have been quarantined in the Discard/Quarantine function are not modifiable.	Low risk/No identified impact	All users	Perform the Discard/Quarantine function within VBECS on blood components that have an attribute of Quarantine upon entry into Incoming Shipment.	The blood product short name and long name clearly indicate that the product is problematic. A blood bank tech would know to update this unit in the computer to a quarantined setting if indicated. Blood centers do not ship quarantined products unless there is a documented medical necessity.	DR 2,616	Type III Blood Product Table Update
Modify Units (not Pool or Split)	When an inappropriate product type is selected for THAW, the user is allowed to proceed but cannot fully complete the modification as there is no target product.	No identified risk/ No identified impact.	All users	None required.	Re-enter the unit with the proper modification method. Code should have prevented the selection of the unit in this modification.	CR 2,286	Type III Blood Product Table Update
Modify Units: Pool Units	When the units selected for a pool have different ISBT 128 attributes for D (Residual Leukocyte Content) or E (Altered), and the method is closed (or a Sterile Connection Device was used with a complete weld), Pool and Thaw/Pool modifications do not find a target.	Low risk/Low impact.	All users	When only ISBT 128 labeled units are included in the pool and the residual leukocyte counts is different, record the pool information manually.	If the group of units to pool includes a Codabar labeled unit, start with the unit that creates a search for a Codabar target. There is a standard residual leukocyte count used in the US.	CR 1,976	Type III Blood Product Table Update
Modify Units: Pool Units	VBECS permits a biohazardous unit to be added to a pool and does not automatically designate the pool as biohazardous. By system design, a biohazardous unit is not automatically marked quarantined to allow processing of a unit that has to be given regardless of this biohazardous state.	Very Low risk/Very Low impact.	All users receiving blohazardous blood unit. (extremely rare).	The user has the option to make the unit quarantined and biohazardous. This includes AUTOLOGOUS.	Unit Short Name displays “QUAR” and the long name includes it as well. Blood centers do not ship biohazardous products unless there is a documented medical necessity. When a biohazardous unit must be added to inventory the blood bank has specific storage and handling policies to segregate this unit from the main blood inventory.	DR 1,984	Type III Blood Product Table Update
Modify Units: Pool Units	During the Pool Unit function the assigned to patient information is not displayed even though the assigned to patient has been selected for the pooled unit.	No identified risk/No identified impact	All users in a division where pooling modification has been enabled.	None required.	Before the pool is saved and proceeding to label verification, VBECS requires confirmation of the patient assignment. This occurs after the patient has been selected by the user during pool modification.	CR 1,629	Type III Blood Product Table Update

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Modify Units: Pool Units	The expiration date/time of a pool target product type of Platelets, Platelets Washed, or Cryo Thawed (E020, E021, or E029) may be short-dated for a closed system processing.	Low risk/Low impact.	All users in a division where pooling modification has been enabled.	The user is able to edit the expiration date/time during modification. This must be verified by the user and the override comments should reflect reference to this system anomaly.	Pooled products are generally processed for immediate use to maximize the time available for transfusion of the product.	DR 2,133	Type III Blood Product Table Update
Modify Units: Pool Units	When pooling ISBT units of differing ABO/Rh types, VBECS indicates the mixed types with a "Mx" rather than "Pooled" designation for the ABO/Rh.	Low risk/Low impact. .	All users	None required.	This is a display only; there is no system-generated blood product label. The nomenclature is described in user documentation.	CR 1,628 CR 1,594	Type III Blood Product Table Update
Modify Units: Pool Units	VBECS allows a user to add a unit to a pool and transfer assignment to the pooled unit when both units are already assigned to the same patient. This creates a unit with dual assignment and the unit cannot be issued.	Low risk/Low impact. Platelets are not generally assigned to patients prior to pooling.	All users	Verify that the pooled unit being edited is not assigned to the same patient or do not move assignments when editing a pool.	Should a unit become assigned in duplicate to a patient and therefore unavailable for issue, use the Release Units From Patient Assignment option to remove the second assignment.	CR 2,387	Type III Blood Product Table Update
Modify Units: Split a Unit	A system error occurs when a user attempts to Split, Discard, or Quarantine a unit and the unit has multiple antigen typing records of the same antigen (e.g., from incoming shipment and from testing).	Low risk/Low impact.	All users	In order to perform the process, Split, Discard, or Quarantine, the user must remove the typing record that occurred in Incoming Shipment or Edit Unit Information by editing the unit, and then perform the split, discard, or quarantine process.	This is associated with a unit record and not a patient.	CR 2,096	Type III Blood Product Table Update
Modify Units: Split a Unit	When red cell products are ABO/Rh confirmed and then split, the confirmation is not inherited by the target units. The split units are not available for selection until a confirmation test is entered for each unit.	Low risk/Low impact.	All users When split modification is enabled at the facility.	Selected for the patient prior to split modification, the split units are issuable to that patient without workaround.	User must enter ABO/Rh confirmation test results on the split units to select them. Unit is available for issue if selected for the patient prior to modification.	CR 2,295	Type III Blood Product Table Update
Modify Units: Split a Unit	When red cell products are antigen typed and subsequently divided, the antigen typing information is not inherited by the target units. When selected in Select Units, the message that the units are not antigen negative displays.	Low risk/Low impact.	All users When split modification is enabled at the facility.	Prepare the original unit for all antigen negative requirements prior to selection and modification. The split units are issuable without override. Ensure that the split units are properly labeled and that the BTRF is correctly printed.	User must enter the antigen typing information on each of the split units before selecting them. Normal business process has the split as the last step prior to issue to maximize the time available for transfusion, unless a sterile connecting device is used.	CR 2,354	Type III Blood Product Table Update

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Modify Units: Split a Unit	When red cell products are divided the CMV negative and SC negative status are not inherited by the target units.	Low risk/Low impact.	All users when a unit with CMV and SC negative units are split. When Split modification is enabled at the facility.	VBECS alerts the user to the missing requirement. The user may proceed, completing the required override documentation.	The user should ensure that the unit is labeled CMV negative per local policy by viewing the Incoming Shipment section of the unit's Unit History Report. The unit record cannot be changed without removing the assignment which then leads to CR 2295 and CR 2,354 (Split units in available status, but unavailable for selection. Split units do not have antigen negative status.). VBECS notifies the user of the lack of computer documentation and allows continued processing for patient use.	CR 2,363	Type III Blood Product Table Update
Modify Units: Split a Unit	An incorrectly formatted date may be entered in the expiration date field; the user is not warned; VBECS saves its calculated expiration date/time.	Low risk/Low impact.	All users when they opt to change the system calculated expiration date of a modified product.	Enter a date/time in the correct format, mm/dd/yyyy hh:mm.	The user may refer to the unit history report for the saved expiration date/time. There is no reason to change the calculated date/time in modification.	CR 2,494	Type III Blood Product Table Update
Order History Report	Canceled orders are not designated on the Order History Report (summary report).	Low risk/Low impact.	Supervisors (When compiling local statistics)	The Single Order History Report (detailed) includes the canceled order information.	Enhancement request to the summary report format. When the order is also cancelled in Vista, which would be the norm, there is a lab report that can be referenced.	CR 1,945	Report Tool Upgrade Project Proposal
Order History Report	The Single Order History Report details the events of each order, rather than all orders, placed for the specimen.	Low risk/Low impact.	Supervisors (When compiling local statistics)	Create an inclusive report for all tests performed on a specimen by viewing or printing each order's history report.	Enhancement request to the single order history repeat to organize by specimen rather than ordered test or component.	CR 1,956	Report Tool Upgrade Project Proposal
Order History Report	VBECS does not provide a message that it is compiling the report.	No identified risk/Low impact.	All users	None available.	The report takes a long time to process (A few minutes). It is not instantaneously generated. This appears to be a Crystal Reports bug. The report information is available through other reports that do not have this delay.	CR 1,846	Report Tool Upgrade Project Proposal
Order History Report	Single Order History Report contains duplicated workload information for TAS and DAT orders.	No identified risk/ No identified impact.	All users	None required.	Correct information is duplicated.	CR 2,159	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Order History Report	Specimen History section of the Order History Report displays historic specimen acceptability incorrectly, in that an acceptable specimen is displayed as unacceptable and vice versa.	No identified risk/Low impact.	All users when a specimen has multiple updates regarding its acceptability.	None required as the current specimen status is correct.	View the record of specimen changes in the Patient History Report, Patient Specimen section where all activities are audited. The current specimen status is correct. The historic information is reversed.	CR 2,337	Report Tool Upgrade Project Proposal
Order Reflex Tests	The Orderable Reflex test for DAT displays as a “DAT” instead of a “Repeat DAT.”	No identified risk/ No identified impact.	All users	None required.	By definition Reflex tests are secondary tests only orderable within VBECS.	CR 1,158	Testing Grids
Order Reflex Tests	Reflex test orders on an expired specimen do not automatically appear on the Pending Task List.	No identified risk/ Very Low impact.	All users	No workaround available for non-maintained expired specimens. Alter a maintainable specimen’s expiration date so it is not “expired” to accommodate data entry. The reflex order is displayed on the PTL using the CPRS order ID search (the CPRS order ID is available on the Order History or Single Order History Reports). Temporarily extend the Maximum Specimen Expiration setting in Configure Division to accommodate the data entry, if needed.	Blood bank tests are rarely performed on an expired specimen. Orders association with an expired specimen are available using the search function and the CPRS order ID. Non-maintained specimens are not associated with component orders. Reflex tests ordered on the date of processing are available.	CR 1,843	Testing Grids
Order Reflex Tests	VBECS displays the Xg(a) blood group antigen incorrectly as” XgA.”	No identified risk/No identified impact.	All users	None required.	Format is understandable to users.	CR 1,881	Testing Grids
Outgoing Shipment	VBECS allows the user to hide columns in the Selected Units section.	No identified risk/No identified impact.	All users	Exit and return to the outgoing shipment invoice; the columns are resized to default width.	If the user wishes to redisplay the column, they simple close and open the option.	CR 116	Maintenance TBD
Outgoing Shipment	The Expiration Date column in the list of units included in the shipment includes only the expiration date.	No identified risk/No identified impact.	All users	None required.	The unit expiration time is displayed correctly on the mock unit label during invoice creation. This does not impede ship out process.	CR 1,980	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Outgoing Shipment	When the return credit field is opened; VBECS enables the OK button although no change is made.	No identified risk/No identified impact.	All users	None required.	VBECS evaluates that no changes were made and no changes are saved to the database. OK button is enabled early which is an inconsistency.	CR 1,981	Maintenance TBD
Outgoing Shipment	Only the last name of a restricted patient displays on the invoice.	No identified risk/No identified impact.	All users	If desired, manually add patient information to the printed VBECS outgoing shipment invoice.	This is a rare event to ship out a restricted unit. The patient surname is adequate to link the physical unit to the patient. Multiple units for different patients in the shipment is very unlikely.	CR 2,041	Report Tool Upgrade Project Proposal
Patient History Report	A target blood unit volume may display as zero during batch processing to irradiate or thaw units. If it does, the target unit volume displays as zero on the Unit History Report.	No identified risk/No identified impact.	All users	Perform single unit modifications when irradiating or thawing units. Alternately, edit the target's volume in Edit Unit Information.	VBECS volume is a default and does not indicate a transfused volume. This is displayed only within VBECS and is updatable.	CR 1,999	Report Tool Upgrade Project Proposal
Patient History Report	When units are restricted for a patient in Incoming Shipments, the restricted units do not display on the Patient History Report.	Low risk/Low impact.	All users	Create a custom look up using the Blood Availability report searching for restricted units with minimal criteria selected, or as applicable to view restricted units in inventory.	Restricted units must be assigned to the patient to display on this report. VBECS forces the user to select this unit with a corresponding component order.	DR 1,643	Report Tool Upgrade Project Proposal
Patient History Report	VBECS displays a transfused volume of "0" on the Patient History Report when the defaults are unchanged.	No identified risk/No identified impact.	All users	When a transfusion was marked as completed in Enter Post-transfusion Information, the volume of the original or modified blood product is available from the Unit History Report.	VBECS volume is a default and does not indicate a transfused volume. This is displayed only within VBECS and is updatable.	CR 1,991	Report Tool Upgrade Project Proposal
Patient History Report	The VBECS domain user name (exp. VHATESTVBECSCLUSTER) will appear in the Processed By Field as having added patients to the database on the Patient History Report.	No identified risk/No identified impact.	All users	None required.	This is accurate but inconsistent as the user's name is usually displayed.	DR 2,580	Report Tool Upgrade Project Proposal
Patient History Report	The Patient History Report displays the NT logon of the user in the Processed By space for database conversion data.	No identified risk/No identified impact.	All users	None required.	The user is identifiable. This is accurate but inconsistent as name is usually displayed.	CR 1,908	Report Tool Upgrade Project Proposal
Patient History Report	"The" is misspelled in the "A patient must be selected for the report" tool tip.	No identified risk/No identified impact .	All users	None required.	Typographical error.	CR 1,703	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Patient History Report	The section separator between Patient Association & Unit Testing is missing.	No identified risk/No identified impact .	All users	None required.	A line is missing between the labeled sections.	CR 2,123	Report Tool Upgrade Project Proposal
Patient History Report	The Exception Type: Expired Task Processed does not display in the Patient History Report.	No identified risk/Low impact.	All users when using the Patient History is used to look up a processed exception rather than the Exception Report.	None required.	The Exception Report is recommended for daily supervisor review and save.	CR 2,133	Report Tool Upgrade Project Proposal
Patient History Report	When an incoming unit is associated to a restricted patient, a duplicate line displays in the Demographics section of the report.	No identified risk/No identified impact .	All users	None required.	Correct information is duplicated.	CR 1,639	Report Tool Upgrade Project Proposal
Patient History Report	In a multidivisional setting, if a patient had a historical ABO/Rh coming from a Transfusion Only (TO) division and the subsequent ABO/Rh testing on that patient is performed in the full-service division, the ABO/Rh result from the TO division is treated as a historical ABO/Rh. When displaying "ABO Discrepant unit issue" or "Unit issued with unsatisfied Transfusion Requirement" exception types on the Exception Report, VBECS calculates the historical system ABO/Rh from the test results entered not the interpretation entered. However, since a TO records only interpretations, these results do not exist and the report displays incomplete information instead of “N/A.”	Low risk/Low impact when at least ONE TO division exists in a consolid-ated database and the most recent blood typing was performed at the TO facility. No identified risk/No identified impact for other division configurations.	All users in a full service division when at least ONE TO division exists in a consolidated database and the most recent blood typing was performed at the TO facility.	None required.	Refer to the Patient History Report or a Patient Selection window to view the full blood type. VBECS uses the TO interpretation correctly as a historical type, the Exception Report does not include the TO typing result. The user will have to refer to the patient’s history report to determine if the typing was performed at the other facility.	CR 2,202	Report Tool Upgrade Project Proposal
Patient History Report	The report displays the (sub) section header not the heading (sub) section on following pages when a (sub) section prints over multiple pages.	No identified risk/No identified impact	All users	None required.	The header is displayed on the first page where the subsection begins.	CR 2,225	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Patient History Report	Post-transfusion information is printed twice on the Patient History Report "Transfusions" section.	No identified risk/No identified impact	All users	None required.	Correct information is duplicated.	CR 2,227	Report Tool Upgrade Project Proposal
Patient History Report	Implicated Units display same information 5 times on report.	No identified risk/No identified impact	All users	None required.	Correct information is duplicated.	CR 2,226	Report Tool Upgrade Project Proposal
Patient History Report	Patient History Report: Antigen Positive/Untested Unit issued exception is listed twice.	No identified risk/No identified impact	All users	None required.	Correct information is duplicated.	CR 2,408	Report Tool Upgrade Project Proposal
Patient History Report	Certain combinations of patient data and the printer settings create a report too large to fit on a page leading to a Crystal Report failure (error).	No identified risk/No identified impact	None	Determine which section is causing the failure and request the report without that section. Locate another report that also displays the problem data, view and print.	Contact your VBECS system administrator to check the printer driver per the Installation Guide instructions. This is typically discovered during local validation and corrected prior to production installation.	CR 2,433	1.5.0.0
Patient Informa-tion Toolbar	VBECS does not display transfusion reactions that are not finalized.	Low risk/Low impact.	All users when a TRW is pending completion and this option is used to look up the information.	Check the PTL for non-finalized transfusion reaction workups.	This test is incomplete without the finalization and is not ready for evaluation using this option.	CR 1,658	Maintenance TBD
Patient Informa-tion Toolbar	The Recent Orders option does not display completed transfusion reaction workups.	Low risk/Low impact.	All users when a TRW is completed and this option is used to look up the information rather than the appropriate use of reports that contain completed test results.	Access transfusion reaction workup information from the patient's Transfusion Reaction History Report or the Finalize/Print TRW option.	This may result in a repeat order of the TRW, which would be cancelled when received and the patient history checked during processing.	CR 1,927	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Patient Testing	When the user clicks the red X button in the upper right corner and clears the test results; VBECS clears the grid but does not disable the OK button when there are results in a second grid.	No identified risk/No identified impact	All users	None required.	The grid is cleared to allow for reentry of results. If the OK button is clicked only the results of the second grid are saved. The test remains pending for reentry.	CR 1,617	Testing Grids
Patient Testing	VBECS does not clear the test interpretation cell when the user clicks the red X in a Transfusion Only division and is in any of the testing grids in Patient Testing.	No identified risk/Low impact .	All users at TO facilities	None required.	Invalidation is accepted only in Invalidate Patient Testing. The intent of the red x is to clear the grid for re entry of reaction results. The user may clear the interpretation cell and re enter the interpretation. VBECS will perform row validation between the entered reaction results and the interpretation enforcing various system rules.	CR 1,644 CR 1,645	Testing Grids
Patient Testing	The pattern IS-N 37-X AHG-P CC-N is considered valid for antibody screen testing.	Low risk/Low impact.	All users	None required.	This is technically acceptable for a prewarmed crossmatch or sites using PeG enhancement. This is allowed with the processing of an override for Nonstandard test methods.	DR 2,140	Testing Grids
Patient Testing	A system error may result when the user tries to enter unacceptable characters or tab where not allowed.	No identified risk/ No identified impact.	All users	None required.	Difficult to reproduce requiring significant manipulation to trigger. Do not tab around needlessly while in the patient testing grids.	CR 2,367	Testing Grids
Patient Testing	When a site is defined as “full service” and daily QC was not performed the Exception Report exception type: “QC not performed on rack used for testing” entry is not saved when the associated patient has a middle initial(MI).	Very Low risk/Very Low impact.	All users when Daily QC was not performed and the patient with an MI is tested.	Standard practice is not to override the QC not performed warning message. Verify the QC was performed daily by reviewing the Testing Worklist Report.	The user is warned that QC has not been performed in all instances. This exception is accurately collected and displayed for unit testing and patients without a middle initial. The user is warned at each testing episode when QC has not been performed and the override is collected in all but a rare situation. There is some flexibility in the 24 hour clock regarding QC testing.	CR 2,402	Testing Grids
Patient Testing	Comments entered in the DAT POS and NEG control cell rows are not displayed on any report in VBECS or CPRS.	Low risk/Low impact.	All users	Enter comments only in the patient test row.	Display should not have multiple comment rows. Comments related to the patient testing are entered in the patient row. This is a training issue. Comments related to the patient test should only be entered in the patient test comment cell.	CR 2,421	Testing Grids
Patient Testing: Pending Task List	The Pending Task List specimen UID field does not read specimen UID barcodes.	Low risk/Low impact.	All users	Enter the specimen UID.	A patient search field is available for use that will present the orders associated with only one patient.	CR 2,056	Testing Grids

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Patient Testing: Pending Task List	When a user enters random alphanumeric characters (nonsense); VBECS may or may not return a list of patients.	No identified risk/ No identified impact.	All users	Enter viable search criteria: full name or first initial of last name and last four digits of the patient ID.	Test sites state that they also use the full SSN for patient identification.	CR 1,891	Testing Grids
Patient Testing: Pending Task List	VBECS contains an order priority of ASAP, however CPRS does not support an order urgency of ASAP so searches on this urgency will not display orders.	No identified risk/ No identified impact.	All users	None required.	Awaiting CPRS correction to include ASAP.	DR 1,967	CPRS 27N. Currently resolved in VBECS Assigned to 1.6.0.0 for testing closure.
Patient Testing: Pending Task List	VBECS does not display the patient's middle initial on the printed Pending Task List.	No identified risk/ No identified impact.	All users	The patient's middle initial is displayed in the Pending Task List user interface.	The online display is normally used.	CR 1,775	Testing Grids
Patient Testing: Pending Task List	VBECS does not include a date range search field.	No identified risk/ No identified impact.	All users	None required.	This is an enhancement request as this is not a normal search usage per the field test sites.	DR 2,586	Testing Grids
Patient Testing: Pending Task List	A system error occurs when the search option "Results Corrected" is used.	No identified risk/ No identified impact.	All users	None required.	A search field, alternate fields are available for use that will present the orders associated with only one patient. Field sites report that they require entry of the patient full SSN or specimen UID to select an order for processing.	CR 2,490	Testing Grids
Patient Testing: Record Patient ABO/Rh	Test entries are not being cleared when canceling out of the Invalid Results message.	Low risk/Low impact.	All users	Correct the testing entries or click the red X to return to the PTL and retest.	None	CR 2,042	Testing Grids
Patient Testing: Record a Cross-match	When the user attempts to save a negative or not tested check cell result, VBECS displays the "Invalid result. Check cells must have a positive result. Repeat test," not "Interpretation does not match your results. Please correct" message.	Low risk/Low impact.	All users	None required.	The message displayed to the user is misleading; VBECS requires entry correction to proceed. The user must enter a valid result.	CR 1,862	Testing Grids

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Patient Testing: Record a Cross-match	A currently crossmatched unit is selected for a different patient. The unit status displays as "Crossmatched."	No identified risk/ No identified impact.	All users when the local practice is to crossmatch a single blood unit for multiple patients.	None required.	VBECS displays the unit status in a hierarchy when a crossmatch is present on any patient or unit and the unit is available for selection, assignment, or crossmatch to another patient.	CR 1,601	Testing Grids
Patient Testing: Record a Cross-match	When returning to partially completed crossmatch tests or testing additional units, the originally selected crossmatch grid configuration is applied.	No identified risk/ No identified impact.	Any user that has saved incomplete test results and returns to enter the remaining results.	None required.	The test is partially completed with a test pattern setting and must be completed in that format. This is a training issue.	CR 1,972	Testing Grids
Patient Testing: Record a Cross-match	A user can bypass the entry of test results in the IS field when performing a crossmatch.	No identified risk/ No identified impact.	All users	None required.	VBECS saves the entered results but does not allow the entry of a crossmatch interpretation while the testing fields are incomplete, as required to accommodate saving partially completed tests. The user may enter their results in any order but may not save the entry until completed.	CR 1,620	Testing Grids
Patient Testing: Record a Direct Antiglob-ulin Test	DAT grid does not properly calculate the QC status of the PS AHG reagent when multiple lot numbers are used on the same day.	Low risk/Low impact.	All users when multiple lots of the same reagent type are in use on that day.	View the QC data for the day for the lot number in question from the Testing Worklist Report and re-enter the results for the test grid (or repeat the testing).	The user may repeat the reagent QC results or look them up and reenter them. The requirement stated that the reagent should not require repeat on the same day. Some sites require retesting of the reagent at each use.	CR 2,179	Testing Grids
Patient Testing: Record a Direct Antiglob-ulin Test	The Anti-Human Globulin reagent lot number entered is not saved when QC is recorded with the patient test. The Patient Testing Worklist Report displays the positive control lot number.	Low risk/Low impact.	All users	Record the reagent lot number for the Anti-Human Globulin in the test comment field.	When the primary AHG reagent is tested with daily QC, there is no issue. This is an issue with subsequent AHG testing associated with an antibody identification where the user must manually add the reagent lot number in addition to the displayed entry.	CR 2,020	Testing Grids
Patient Testing: Antibody Identificat ion	Users cannot remove an antibody specificity (with no corresponding antigen negative requirement) if entered as an ABID test. This will lead to CR 2,483.	Low risk/Low impact.	All users	The antibody cannot be removed by the user. Contact product support to create a Remedy ticket. The VBECS team will make the correction. Enter the antibody identify in special instructions as there is no associated antigen negative requirement.	Limited to antibody specificities that do not and cannot have an antigen negative requirement that may be entered in the ABID test: *Anti-I, Anti-i, Cold auto-antibody, Warm auto-antibody, HTLA (probable), Antibody to Low-Incidence Antigen, Antibody, No Specificity Identified, Antibody to High-Incidence Antigen.* These antibodies do not have an associated antigen negative requirement for evaluation.	CR 2,489	1.5.0.0

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Patient Testing: Record a Direct Antiglob-ulin Test	VBECS displays “IgG” instead of “Anti-IgG” in the Tested With column of the Patient Testing Worklist Report.	No identified risk/ No identified impact .	All users	None required.	Reagent name is clear as this is the only reagent with this name.	CR 1,638	Testing Grids
Patient Testing: Record a Patient Antibody Screen	VBECS displays a system error message when the user clicks a tab for antigen testing, does not enter any test results, and clicks Cancel and Yes to close the window.	No identified risk/ No identified impact.	All users	Do not cancel out of testing without entering test results.	The user has indicated to exit this option. The user must log into VBECS to continue.	CR 1,797	Testing Grids
Patient Testing: Record a Transfu-sion Reaction Workup (TRW)	When a second implicated unit is selected prior to the completion of the first unit, VBECS does not record the associated data entry for the second unit.	Low risk/Low impact.	All users	Add the first unit completely, and then add subsequent units.	Details affected are the Bag Returned information, hemolysis, Checks OK, and Comments. This does not occur when the user selects units for entry from left to right. The user may invalidate the TRW testing prior to finalization and enter the data.	CR 2,053	Testing Grids
Patient Testing: Record a Transfu-sion Reaction Workup (TRW)	A system error occurs when a user attempts to access a transfusion reaction workup that is already in progress and locked by another user.	No identified risk/ No identified impact .	All users	None available.	Simultaneous data entry on the same order is not allowed to avoid data corruption. They must log into VBECS to continue with other orders.	CR 2,215	Testing Grids
Patient Testing: Record a Transfu-sion Reaction Workup (TRW)	Date Reaction Noted and Date Reaction Investigated is updated and reset to the current division date/time each time the TRW is opened for editing.	No identified risk/ No identified impact .	All users	None required.	The Date Reaction Noted is recorded correctly and displayed as first entered on the Patient History Report. This is a display issue only as the original Date Reaction Noted is correctly recorded in the database and on the report.	CR 2,218	Testing Grids

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Patient Testing Worklist and Testing Worklist Reports	Report Testing Worklist is missing its Title and cannot be scheduled.	No identified risk/ No identified impact.	All users attempting to print the report; Supervisor is responsible for reviewing the report.	Print the report and immediately write the title of the report on the pages.	The report may be printed on demand. The title may be written on the report manually, if required. This is the only report that contains the reaction results and is clearly the Testing Worklist Report.	CR 2,070	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	Crossmatch tests that were invalidated and retested are not marked on the testing report.	No identified risk/ No identified impact .	Supervisor responsible for report review	The sequence of test performance by date and time on the report identifies the most recent result.	This is a training issue. The tests are displayed in the order of testing.	CR 2,034	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	The Testing Worklist Report does not display the “Entered in Error” comment when a Unit ABO/Rh Confirmation Test is invalidated.	No identified risk/ No identified impact .	Supervisor responsible for report review	None required.	The unit has a status of “Limited” and is not available for patient selection. The unit is properly restatused with the test invalidation. The invalidated result is included on the report for review. The supervisory review would require minimal additional time.	CR 2,083	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	”Automated Instrument” does not display on the report.	Low risk/Low impact.	Supervisor responsible for report review	Add instrument information from the instrument output during the report’s review.	The results from an automated instrument must be entered by a VBECS user whose name displays. This is not incorrect but does not include the secondary information that the test was performed with a specific instrument.	CR 2,046	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	The generation of testing reports may be prolonged.	No identified risk/ No identified impact .	Supervisor responsible for report review	The report can be scheduled to print.	This report is printed for review. This is dependent on the amount of data being retrieved.	CR 1,867	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Patient Testing Worklist and Testing Worklist Reports	Rack IDs are not consistently displayed in the Patient Testing Worklist Report.	No identified risk/ No identified impact .	Supervisor responsible for report review	None available.	1) The one letter rack IDs are supposed to appear in the first line of the testing entry. In many cases, it is appearing in seemingly random line number positions, sometimes appearing multiple times in one testing entry. 2) When an XM test is invalidated, the Rack ID is not displayed. The missing rack IDs are an artifact when the same rack is used for the series of tests.	CR 2,063	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	The lot number is not displayed for invalidated tests.	No identified risk/ No identified impact.	Supervisor responsible for report review	None required.	The lot numbers are displayed with the original display of the results. This is a second presentation of the set of results.	CR 2,025	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	The weak D report format includes line items for IS and RT although these phases are disabled in the testing grid and may never have entered results.	Low risk/Low impact.	Supervisor responsible for report review	None required.	The report displays these phases with no results when none have been entered.	CR 2,040	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	The Patient Testing Worklist Report displays "Inc" for test interpretations that have different meaning. In the Interpretation column for crossmatch tests, “Inc” means incompatible; for other diagnostic tests, “Inc” means “inconclusive” interpretation.	No identified risk/ No identified impact.	Supervisor responsible for report review	None available.	Crossmatch test does not include an “inconclusive” interpretation. Other diagnostic tests do not have an “incompatible” interpretation. The definition is associated with the particular test and is not confusing to the blood bank staff.	CR 2,032	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	VBECS displays an extra comma after the last specimen UID when a patient has multiple associated specimen UIDs.	No identified risk/ No identified impact .	All users	None required.	Extra comma does not interfere with the displayed data.	CR 1,579	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Patient Testing Worklist and Testing Worklist Reports	Testing Worklist Report: Unit and Patient Testing Details window reflects the reagent rack's testing status on the current date not on previous dates (retrospective data entry) and may require an override to proceed.	No identified risk/ No identified impact .	Supervisor responsible for report review	None Available.	Verify that QC was performed on the selected date(s) using the Testing Worklist Report. This is a report pulled for review and part of that review is to review that QC was properly performed on each date selected for the report.	CR 2,384	Report Tool Upgrade Project Proposal
Patient Testing Worklist and Testing Worklist Reports	Testing Worklist Report does not provide a comprehensive list of reagent lot numbers entered for daily reagent rack QC.	Low risk/Moderate impact.	All users	Continue to record all reagent lot numbers on a rack with existing process (hard copy or spreadsheet). Retain with Testing Worklist review records.	The user must record some lot numbers manually as they are not displayed on the report. Field sites have opted to continue current manual recording of all lot numbers to minimize confusion.	CR 2,385	Report Tool Upgrade Project Proposal or Daily Reagent Quality Control Upgrade
Patient Updates	VBECS performance will slow when a patient has ten or more active ordered components because it must calculate the active orders for each patient checked.	Low risk/Low impact.	All users	None Available.	It is unlikely that this will occur unless the patient has multiple duplicate orders for the same blood component.	CR 2,177	Maintenance TBD
Post – Transfu-sion Informa-tion	When a unit is marked as Presumed Transfused, the transfusion time defaults to the issue time, and it is indicated that there was no reaction. Units marked Presumed Transfused are unavailable to Enhanced Technologists and lower levels for update.	No identified risk/ No identified impact.	Technologists only	None required. Edit the transfusion information, as necessary (Lead Technologist or higher security role).	The user that is able to edit the units is able to retrieve all of the units.	CR 1,961 CR 1,963 CR 2,461	VBECS BCE Interface Project
Post – Transfu-sion Informa-tion	The default start and stop times are earlier than the current time. The user can enter an end date and time earlier than the start time.	No identified risk/ /Low impact.	All users	Review and edit the start and end time of the transfusion and check the entries for validity prior to saving.	Any presented start and stop date must be reviewed for accuracy and entry.	CR 1,653 CR 1,654	VBECS BCE Interface Project
Post – Transfu-sion Informa-tion	VBECS allows the user to set a transfused volume to an amount greater than the default average volume associated with the product code in Blood Products.	No identified risk/ No identified impact.	All users	None required.	This may actually be a benefit as an accurate transfused may be entered. The default product volume is an average, not the maximum.	CR 1,655	VBECS BCE Interface Project

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Post – Transfu-sion Informa-tion	The Presumed Transfused indicator does not clear when post-transfusion information is updated.	No identified risk/ No identified impact .	All users	None required.	The transfusion end date is maintained properly in the database; the Presumed Transfused indicator is retained. The updated transfusion data are displayed in the Unit History Report. This may actually be a benefit as the record is clearly marked and indicates that the update occurred over 48 hours after administration and may require investigation as to why the information was not earlier made available.	CR 1,936	VBECS BCE Interface Project
Post – Transfu-sion Informa-tion	The OK button in the Document ABO Incompatible Transfusion window does not activate when all fields are populated and the cursor remains in one of the data fields.	No identified risk/ No identified impact .	Supervisors when documenting a transfusion event that did not follow normal process flow.	Press the tab key after completing the last required entry to exit the completed field.	This is a training issue. Tabbing out of the last entry is required as normal processing. This is a rarely used option.	CR 1,656	VBECS BCE Interface Project
Post – Transfu-sion Informa-tion	No warning displays for missing workload process when entering post-transfusion information.	No identified risk/Low impact.	Supervisor responsible for workload reporting.	None required.	Associate workload process with Enter Post-transfusion Data. The application does behave correctly when a workload process is defined.	CR 2,263	VBECS BCE Interface Project
Post – Transfu-sion Informa-tion	A system error occurs when entering post-transfusion information if the tabs are selected out-of-order.	Low risk/Low impact If VBECS error occurs no data is saved and the information must be re-entered.	All users	Enter the tabs in order presented to avoid causing VBECS error.	If a VBECS error occurs no data is saved and the information must be re-entered.	CR 2,208	VBECS BCE Interface Project
Post - Transfu-sion Informa-tion	A system error displays if the VistALink connection is lost while using this option.	No identified risk/ No identified impact.	All users	User must log back into VBECS.	Reenter any data that was not saved prior to the error.	CR 2,372	VBECS BCE Interface Project
Post – Transfu-sion Informa-tion	When a facility does not routinely enter post-transfusion information, a user must open the option Enter Post-transfusion Data to make information available to the DSS extract message.	Low risk/Low impact.	Supervisors	Enter and exit this option at least once daily to avoid lost data for the DSS update.	Recommend a daily task to log into this option to avoid lost data for the DSS update if the site uses the presumed transfused functionality. Simply open and close the option; no data entry is required.	DR 2,891	VBECS BCE Interface Project

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Post – Transfu-sion Informa-tion	When the Transfusion Start Date is edited and the same date/time as the Issue Date/Time is entered, the OK button remains disabled.	No identified risk/Low impact.	All users	Enter a start time that is at minimum one minute later than the issue time.	This requires the user to enter a start time that is at minimum one minute later than the issue time.	CR 2,500	VBECS BCE Interface Project
Post – Transfu-sion Informa-tion	When a Technologist or Enhanced Technologist attempts to enter post-transfusion information the Transfusionist ID fields are always disabled.	No identified risk/ Low impact.	Technologists only	None required.	This is an inconvenience to the staff as only Lead Technologist and up can enter transfusionist. This does not prevent that user from entering the other transfusion data.	CR 2,500	VBECS BCE Interface Project
Print Unit Caution Tag & Transfu-sion Record Form	A system error occurs when attempting to print the BTRF when an antibody with no antigen negative requirement has been entered in the patient record. Refer to CR 2,489.	Low risk /low impact.	All Users	Inactivate the antibody through the Special Instructions, Transfusion Requirements option. Enter the antibody identity in special instructions as there is no associated antigen negative requirement.	Limited to antibody specificities that do not and cannot have an antigen negative requirement: *Anti-I, Anti-I(int), Anti-LW, Anti-Le other, Anti-Lu, Anti-M other, Anti-N other, Anti-i, Anti-rhesus, other, Anti-rhesus, NOS, Antibody to Low-Incidence Antigen, Antibody, No Specificity Identified, Antibody to High-Incidence Antigen, Cold auto-antibody, HTLA (probable), Warm auto-antibody.* The user would complete a backup form for all units associated with this patient, IF the antibody was entered and could not be inactivated. This is considered low impact due to the nature of the antibodies. Enter the antibody identify in special instructions as there is no associated antigen negative requirement.	CR 2,483	1.5.0.0
Print Unit Caution Tag & Transfu-sion Record Form	VBECS displays a message that the caution tag(s) were successfully printed, but the printer has failed and printing was not successful.	No identified risk/ No identified impact.	All users	Physically verify that the requested tag is printed. The "Success" message is a message that the print has queued to the print queue, and does not verify that the printing has actually occurred.	If the tag didn't print, the user would reprint the tag. The tag usually has printed successfully without incident.	CR 2,059	Report Tool Upgrade Project Proposal
Print Unit Caution Tag & Transfu-sion Record Form	A VBECS system error occurs when a Caution Tag is requested and the printer is not correctly configured.	No identified risk/ No identified impact.	All users	Configure the printer as detailed in the VBECS installation guide with subsequent testing prior to use.	This will be discovered during local validation and corrected prior to production installation.	CR 1,660	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Print Unit Caution Tag & Transfu-sion Record Form	The printed Caution Tag displays “Not Applicable” in the crossmatch field when a unit does not require a crossmatch. The Blood Transfusion Record Form (BTRF) displays “Not Required” in the same situation.	No identified risk/ No identified impact.	All users	None required.	The messages are materially equivalent. If the user feels that this is unacceptable they would manually change the text on one of the documents to match letter for letter with the other.	CR 2,007	Report Tool Upgrade Project Proposal
Print Unit Caution Tag & Transfu-sion Record Form	When an antigen negative requirement was entered in Special Instructions and Transfusion Requirements, the message and tool tip includes the antigen negative requirement in a sentence structured for an antibody history insertion.	No identified risk/ No identified impact.	All users	None required.	The statement is grammatically incorrect but conveys that the unit is untested or positive for the required antigen to a Blood Bank user.	CR 1,814	Maintenance TBD
Print Unit Caution Tag & Transfu-sion Record Form	The Product Code and/or Short Name does not appear on the caution tag.	No identified risk/ No identified impact .	All users	None required.	The product code is one of the fields contained in the barcode on the caution tag and the full description of the product is included in the Blood Transfusion Record Form.	DR 1,704	Report Tool Upgrade Project Proposal
Print Unit Caution Tag & Transfu-sion Record Form	VBECS cannot print a BTRF documenting retrospective crossmatch compatibility.	No identified risk/ No identified impact	Supervisor reviewing retrospective data entry related to emergency issue of blood products	None required.	The information is available in the various reports associated with testing documentation. The user may want to write up a document “for the re cords” based on paper record driven policy for documentation for retrospective test entry related to the issuance of blood products with incomplete pretransfusion testing. This form is not required as one has already been written and used to document the blood product administration.	DR 1,956	Report Tool Upgrade Project Proposal
Print Unit Caution Tag & Transfu-sion Record Form	Remove the ">" from the message: >This order must be emergency issued at this time. This unit does not qualify for emergency issue. Tag(s) cannot be printed.	No identified risk/ No identified impact	All users	None required.	The statement is grammatically incorrect but is clear to a Blood Bank user.	CR 2,086	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Print Unit Caution Tag & Transfu-sion Record Form	When blank Caution Tags are printed in preparation for down time and the print job is canceled, the number printed is not correct in the message.	No identified risk/ No identified impact	All users	None available.	The user may count the number of tags printed to determine how many blank tags should be printed.	CR 2,003	Report Tool Upgrade Project Proposal
Print Unit Caution Tag & Transfu-sion Record Form	Patient name may exceed the allotted space when it is very long.	Low risk/Low impact.	All users	None required.	The user would complete a backup form for all units associated with this patient. This is considered low impact as the likelihood of a patient having a name that is over 40 characters long is small.	CR 2,454	1.6.0.0
Product Modifica-tions (Division Configur-ation)	When a user enters an amount less than 0.00 or greater than 9999.99 in a Cost field and presses the Enter key, VBECS changes the amount to 0.00 and 9999.99, respectively, and enables the OK button.	Low risk /Low impact.	Administrator	Check the cost field entries for validity prior to saving.	This is a configuration option where an upper level user is defining the cost of the process. VBECS will save the cost at the maximum allowed number.	CR 1,732	Type III Blood Product Table update
Prolong-ed Transfu-sion Time Report	When the user clicks OK after selecting the printer, the print preview view of the Prolonged Transfusion Report closes.	No identified risk/ No identified impact	All users can print the report, but a Supervisor would be responsible for review	None available.	The user has requested the hard copy and no longer requires this view. This is not consistent with other reports in the application.	CR 2,231	Report Tool Upgrade Project Proposal
Prolong-ed Transfu-sion Time Report	The delayed start time presented is the total time from issue to start time; the prolonged transfusion presented is the time from issue to the transfusion end time.	No identified risk/ No identified impact	All users can print the report, but a Supervisor would be responsible for review	None available.	The times are not inaccurate but are not in the preferred format where a delayed start would calculate only 30 minutes after issue to the start for its calculation (example, 34 minutes, not 4 minutes). The prolonged transfusion would be from the start to end time that exceeds the maximum transfusion time (MTT) set for the component class, for example, 500 minutes, not 30 minutes when maximum MTT is 470. This is a report for a transfusion committee. The data is accurate, but does not present as the VBECS business rule is written.	CR 2,499	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Reagents	Once tripped, the message warning of low reagent inventory continues to alert the user in Update Reagents even when the inventory is above the minimum.	No identified risk/ No identified impact	All users	Set the "Minimum Stock Vial Level" in Maintain Reagent Minimum Inventory to zero to disable the warning message.	This is an annoyance that is corrected by resetting the configured number to zero for the specific reagent lot number.	CR 1,505	Daily Reagent Quality Control Upgrade
Reagents	When reagents are received, updated and marked unsatisfactory in the same transaction; comments and details entered are concatenated and are not displayed on the Reagent report.	Low risk /Low impact.	All users can print the report, but a Supervisor would be responsible for review	Document the reason a reagent was unsatisfactory upon receipt on the manufacturer's invoices for future reference.	None	CR 1,875	Daily Reagent Quality Control Upgrade
Reagents	VBECS does not maintain a reagent lot number's history when the quantity of an expired reagent is set to zero.	Low risk /Low impact.	All users can print the report, but a Supervisor would be responsible for review	Do not set the reagent lot number quantity to zero when the record is to be maintained.	This is an expired reagent and would not be used routinely. The lot number continues to be available for use should that be the case.	CR 1,958 CR 1,931	Daily Reagent Quality Control Upgrade
Reagents	A warning icon appears when the user selects "No" to the entry confirmation message.	No identified risk/ No identified impact .	All users can print the report, but a Supervisor would be responsible for review	Click the Clear button to continue.	The user must click clear to close the window. This is a nuisance in a non-patient care option in the application.	CR 1,952	Daily Reagent Quality Control Upgrade
Reagents	The Vials Received per Lot Number field in Log In Reagents allows the entry of a decimal that causes the reversal of the entry (e.g., user entry of 1.5 becomes 51).	No identified risk/ No identified impact .	All users can print the report but a Supervisor would be responsible for review	Enter whole numbers; do not enter decimals. Check the accuracy of the entry before saving.	This is a nuisance in a non-patient care option in the application.	CR 2,067	Daily Reagent Quality Control Upgrade
Reagents	Previously entered manufacturers' names may not persist in the manufacturers' drop-down list in Log In Reagents.	No identified risk/ No identified impact .	All users can print the report but a Supervisor would be responsible for review	Enter the manufacturer's name.	This is a nuisance in a non-patient care option in the application.	CR 1,501	Daily Reagent Quality Control Upgrade

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Reagents	VBECS allows the entry of only free-text comments after revising fields when the user selects “Other” from the Reason for Change drop-down list.	No identified risk/ No identified impact.	All Users	None required.	This is consistent with the selection of the comment “OTHER” in the rest of the application.	CR 1,486	1.5.0.0
Reagents	The warning message displayed when the user exceeds the upper limit of the Vials Received field in Log In Reagents states the range as 0–999 when it is actually 1–999.	No identified risk/No identified impact.	All users can print the report but a Supervisor would be responsible for review	None required.	The lower range is incorrect in the documentation. The upper limit is the same in both cases.	CR 1,910	Daily Reagent Quality Control Upgrade
Reagents	When the inclusive dates entered for Expiration Date Before/After include the current date, reagents that expire on the current date may not be included.	No identified risk/No identified impact.	All users can print the report but a Supervisor would be responsible for review	None required.	The reagent is not expired on the date the report is requested. The reagent is available.	CR 1,966	Daily Reagent Quality Control Upgrade
Reagents	Anti Pk, Anti-PP1, Anti-I, and Anti-I(int) are available as reagent types with no corresponding active test.	No identified risk/No identified impact	All users can print the report, but a Supervisor would be responsible for review	None required.	There are no associated test for these antigens in VBECS.	CR 1,882	Daily Reagent Quality Control Upgrade
Reagents	VBECS truncates text in the print preview and printed versions of the Reagent Inventory Report. When VBECS does not find a match for selections entered in the Reagent Search window, it creates a report with “No Reagents Found” instead of presenting a message that no match was found.	No identified risk/No identified impact	All users can print the report, but a Supervisor would be responsible for review	None required.	This is an inconsistent response.	CR 1,515	Daily Reagent Quality Control Upgrade
Reagents	The time defaults to the time when the user enters the Reagent, Update Inventory window, not the time when a lot number is selected.	No identified risk/No identified impact	All users can print the report, but a Supervisor would be responsible for review	None required.	As the report is generated after the user enters the option, this would not be a significant time difference that would impact the information in the report.	CR 2,068	Daily Reagent Quality Control Upgrade

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Reagents	In a multi-divisional environment, the reagent report for a division will print one line item for each division that has set minimum levels for that reagent type. For example, if you have minimum levels for Reagent A, and 2 other divisions on your VBECS have minimum levels for Reagent A, your division's reagent information will print three times on your report.	No identified risk/Low impact in a consolidated division No identified risk/No identified impact in a single division database And in consolidated database where not all facilities set minimum reagent levels.	All users can print the report, but a Supervisor would be responsible for review	None required.	There is no crossover of data and no safety issue. If minimum levels are not set in a division, then it will not factor into the display. In a single-division environment, there is no problem. Correct information is duplicated. This occurs only in consolidated divisions.	CR 2,233	Daily Reagent Quality Control Upgrade
Release Units From Patient Assign-ment	The scanner icon is currently displayed but is not working.	No identified risk/No identified impact	All users	None required.	This is an inconvenience. The user may opt to release units using the patient route rather than the unit driven route.	CR 2,200	Maintenance TBD
Return Issued Units To Blood Bank	When all assigned units are released, the component order status is returned to "Not Started" on the Pending Task List.	No identified risk /No identified impact.	All users	None required.	The order remains available for use and expires normally based on division settings. This is viewed as a training issue. The order status is calculated based on the units currently associated with the order.	CR 2,051	Select Unit Project Proposal
Return Issued Units To Blood Bank	VBECS may display an inactivated unit in the unit search screen without any indication of its inactivated record status.	No identified risk /Low impact.	All users	None required.	All unit information is correct.	CR 1,877	Select Unit Project Proposal
Return Issued Units To Blood Bank	Visual Inspection Information is not included in Exception Report.	No identified risk /No identified impact.	All users	View the Unit History Report for the visual inspection associated with an exception recorded for a blood unit relocation.	The display of the visual inspection response is included in the unit's Unit History report which may be opened during the investigation of the exception by the supervisor.	CR 2,119	Select Unit Project Proposal

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Return Issued Units To Blood Bank	The selected unit marked unsatisfactory for return is removed from the Select Units to Return list view, but the information in the Selected Unit pane for the unsatisfactory unit remains unchanged.	No identified risk /No identified impact.	All users	None required.	The display changes when another unit is selected and updates the view.	CR 2,089	Select Unit Project Proposal
Select Units	In a multidivisional database, restricted units residing in another division will be displayed but are not selectable. The tool tip (mouse over) message wording incorrectly states, "Unit is **not** in division ###."	No identified risk /No identified impact.	All users in consolidated VistA with multiple VBECS Divisions	Read this message without the word NOT in the sentence. The division shown is the division where the unit is physically located.	The unit is not selectable as it is physically in a different location. This occurs only in consolidated divisions which are limited in number and with restricted units which are not a high volume product.	CR 2,107	Select Unit Project Proposal
Select Units	VBECS displays ISBT unit ID and product short name, but not the product code. A split ISBT unit's uniqueness is determined by the seventh and eighth digit of the product code; therefore, VBECS cannot identify the difference.	Very Low risk / Very Low impact. No identified risk/No identified impact when SPLIT modification not enabled at the facility.	All users in divisions where split unit modification is enabled.	None available.	The user scans/enters the product information and does not use the pick list.	DR 1,729	Select Unit Project Proposal
Select Units	VBECS blood product table does not include the ICCBBA classes Thawed POOLED PLASMA (E055), Thawed POOLED FRESH FROZEN PLASMA (E056), WASHED GRANULOCYTES (E057) and Liquid POOLED PLASMA (E058).	No identified risk/No identified impact.	None.	None required.	The product codes associated with these blood product classes are available for use and the class changes are for mapping tables that are not visible to the user.	DR 1,703 DR 1,707	Select Unit Project Proposal
Select Units	The message used to state that the patient has a history of Anti-K and the unit is positive for the antigen K, references the antigen type as anti-K and the antibody as K as well as all other antibody/antigen pairs.	No identified risk/No identified impact.	All users when the patient has an identified irregular antibody and selected an untested or positive unit for the patient.	None required.	The terms are flipped but the content of the message is clear to a blood bank user.	CR 2,093	Select Unit Project Proposal

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Select Units	Blood product 00950 E001 WB CPD is listed as WB ACD-B in the short name and 27223 E002 RBC CPDA-1 is listed as RBC CP2D in the short name.	No identified risk/No identified impact.	All users	None available. The core conditions and expiration dates are correct for these products.	The short names include the incorrect anticoagulant listing. VBECS rules are not dependent on this information and enforce correct handling.	DR 2,703	Select Unit Project Proposal
Select Units	Thaw warning message for Frozen APHERESIS RED BLOOD CELLS does not display when selecting the unit.	Very Low risk/ Very low impact.	All users in a facility where frozen blood is received and the modification deglycerolization is enabled.	None required.	Frozen products are selectable for issue. The use of frozen red cells is rare and usually processed by the blood center not the VA blood bank.	DR 1,661	Select Unit Project Proposal
Select Units	Autologous, directed, or designated or dedicated blood units located in one division of a multidivisional database do not display in another division if the status is assigned or crossmatched.	Low risk /Low impact.	Limited to all users in consolidated VistA with multiple VBECS Divisions	None required.	Release the unit from assignment; the patient is no longer in the facility. Transfer any autologous or directed and assigned units with the patient. This assumes that the patient has been moved and physically in the other site while the restricted unit is actively selected for the patient. This requires a current specimen and its testing. This is a very unusual circumstance as autologous and directed units are generally associated with elective surgical procedures where a patient transfer is not common.	CR 2,050	Select Unit Project Proposal

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Select Units	When there is a patient blood typing discrepancy and the unit does not meet requirements for selection, VBECS displays a warning with text that is not worded exactly as specified. System message displayed "VBECS- Not selectable unit [unit number]. This order must be emergency issued. This unit doesn't qualify for emergency issue and may not be selected."	No identified risk/No identified impact.	All users when an ABO discrepancy is found during the course of testing a selected patient.	None required.	VBECS is working correctly and enforcing the emergency issue compatibility rules and issuing universally compatible unit(s). ABO discrepancy is an uncommon occurrence in a transfusion service regardless of the root cause. The patient ABO/Rh discrepancy information is available in the Patient History or Exception Report. The message should read: "This patient had a previous ABO/Rh discrepancy and entry of a justified blood type with the following comment: <insert type of discrepancy from record>. Perform ABO/Rh on the current specimen to continue using normal rules and policies or follow emergency issue rules and policy as related to patient ABO/Rh retrieval and blood compatibility."	CR 1,548	Select Unit Project Proposal
Select Units	The Unit Expiration field is blank prior to the unit selection confirmation.	No identified risk/No identified impact.	All users	None required.	The unit expiration displays when a unit is selected. The expiration date is always displayed on the mock face label. The information is accurately displayed on the screen, just not in this specific field.	CR 1,899	Select Unit Project Proposal
Select Units	When a user selects an antigen positive unit for a patient with an antigen negative requirement; VBECS displays the product name instead of product type in the warning message.	No identified risk/No identified impact.	All users	None required.	The long product name contains more information than the product type for the unit.	CR 2,010	Select Unit Project Proposal
Select Units	VBECS displays a Codabar product code with an appended donation type code in the tree view of Select Units for Patients.	No identified risk/No identified impact.	All users	None required.	Codabar product codes do not require the appending of the donation type. This appended donation type information is correct for the unit.	CR, 2030	Select Unit Project Proposal
Select Units	When the patient's blood type is unknown or inconclusive and the user uses the unit search option, VBECS displays available cryoprecipitate units for selection without grouping the units by blood type.	No identified risk/No identified impact.	All users	None required.	Available units are displayed correctly. Click the ABO/RH column header of the available unit list to reorganize the unit list by blood type, as desired.	CR 1,727	Select Unit Project Proposal
Select Units	When associating a specimen with a patient in the "Select Unit for a Patient" window; the "Expires" field within the "Associate with Specimen" panel, displays the time in AM/PM format.	No identified risk/No identified impact.	All users	VBECS normally displays date/time fields in the "military" time format. Workaround is to look in Maintain Specimen and check the expiration time military time format.	This is an inconsistent presentation which does not impede the user.	CR 2,120	Select Unit Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Select Units	The display of Unit ID/Product Code for Codabar labeled units may display an ISBT 128 type code at the end of the number.	No identified risk/No identified impact.	All users	Select the tree view of the unit information where the full screen displays correctly.	None	CR 2,030	Select Unit Project Proposal
Select Units	The message displayed reads "Original and repeat ABO/Rh interpretation do not match." The 2nd sentence in the designed message "You must resolve the discrepancy before units can be issued." is not displayed.	No identified risk/No identified impact.	All users	None required.	VBECS will not allow the user to proceed with specimen processing until the discrepancy is resolved.	CR 2,203	Select Unit Project Proposal
Select Units	The Lab Order number does not display when the clipboard icon tool is selected.	No identified risk/No identified impact.	All users	User can view the Lab Order number using the Pending Order List or the Order History Report.	The lab order is available on those screens where it is needed. This is an additional display of the information that is not essential to the user.	CR 2,190	Select Unit Project Proposal
Select Units	When the patient's historic blood type from database conversion or previous testing is Rh Positive and the current specimen is unknown VBECS is not generating the message "Patient is Rh negative and the selected unit is Rh positive."	No identified risk/No identified impact.	All users when selecting an RH positive unit for a currently untested specimen where the database conversion blood type is Rh positive.	None required.	When the current testing is performed and the patient is Rh negative in conflict with their historic Rh information, VBECS does document the problem and alert the user. Issue of Rh Positive units to a patient where incomplete testing exists regardless of the historic typing does require override processing by the user at issue. This is a preliminary warning to the user, the mitigation is at Issue Blood Product.	CR 2,219	Select Unit Project Proposal
Select Units	When a Rh positive unit is selected for a Rh neg patient with anti-D, the Enhanced Technologist does not receive the warning that unit is antigen positive.	No identified risk/No identified impact.	Technologists when selecting Rh positive blood products for an Rh negative patient.	None available. The warning message for selection of an Rh positive unit for an Rh negative patient does appear.	A Lead Technologist is required to issue this unit to the patient and an exception is collected. Issue Unit is handling this situation correctly as designed.	CR 2,406 DR 3,020	Select Unit Project Proposal
Select Units	A system error occurs when attempting to associate a specimen in Select Unit with an order when no unit is selected.	No identified risk/No identified impact.	All users, retrospective data entry when specimen has not been associated during Accept Order.	Ensure that a unit is selected when associating a specimen UID with units processed without a specimen for emergency issue.	Alternately, associate the specimen UID in Accept Order when possible. The user is attempting to associate the specimen to nothing. A unit must be selected. This is in place to allow users to associate a specimen with blood products for retrospective testing after the unit has been processed in emergency circumstances.	CR 2,411	Select Unit Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Select Units	A system error occurs when the user clicks very quickly on the multiple messages in select unit regarding eXM eligibility and printing tags/forms.	No identified risk/No identified impact.	All users who are clicking faster than the messages can be read and responded to.	View, read, and respond to the presented messages.	This has been identified is a training issue and possible enhancement to consolidate redundant messages for the selected units. The user is "counting" and clicking ahead of VBECS message presentation. The original information is saved, but VBECS crashes due to the database constraint violation. The user is clicking faster than the messages can be read and responded to.	CR 2,501	Select Unit Project Proposal
Select Units	Electronic crossmatch is allowed for patients with an antibody specificity that originated from a legacy record (database conversion).	Low risk /Low impact.	All users when a legacy antibody has not been processed after database conversion in the production account. Supervisor is responsible for executing the work around immediately after database conversion and prior to production use of VBECS.	Obtain the production account database conversion records. The spreadsheets from this activity contain the full list of the patient records that require processing. Log into VBECS: click PATIENTS and then SPECIAL INSTRUCTIONS & TRANSFUSION REQUIREMENTS. Enter the name or identifier of the selected patient, and in the PATIENT SEARCH field click SEARCH. The SPECIAL INSTRUCTIONS & TRANSFUSION REQUIREMENTS window opens. Click on the ANTIBODIES IDENTIFIED tab, the antibody from database conversion is marked "VistA Converted". Select the antibody from the list again for that patient. Click ADD. Repeat step 4 and 5 for all antibody specificities with an origin of "VistA Converted". When the update is complete, click OK to save the antibody entries for that patient. Repeat for all patients with antibodies from database conversion. Print the Audit Trail report and verify that all the patient records were successfully updated. Outcome: The patient is no longer eligible for electronic crossmatch due to the "A" status in the database. The patient's TR will display the VistA Converted entry and the update. The VistA converted entry may be inactivated.	Note that legacy Special Instructions processed during the database conversion may contain transfusion requirements which require manual entry on the Transfusion Requirements tab to enforce them. All database conversion records require additional review to move the transfusion requirements in the special instructions to the transfusion requirements field. The user needs to change the status of the antibody by adding them again.. It is recommended that the site do this immediately after database conversion.	CR 2,502	1.5.0.0
Server System Adminis-trator	Microsoft Windows limits the number of non-interactive processes on the server. On rare occasions when the limit is exceeded the VBECS patch process will fail. User will be notified by message: "Error: occurred during VBECS application lock processing on the server." Repeat the patch process.	No identified risk/ No identified impact.	System Administrator	Reboot prior to the report patch process.	This may occur during the patch process when users are currently off line due to the patch installation. The administrator would reboot the system. A slightly longer downtime may occur.	CR 2,234	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Server System Administrator	Remove Para-Bombay and Bombay from database table.	No identified risk/ No identified impact.	None	None required.	These are extremely rare blood type variants that are not used in VBECS but exist in the database table.	CR 1,926	Maintenance TBD
Server System Administrator	Locking: a system error occurred when the user opened the Invalidate Patient Test Results window.	No identified risk/ No identified impact.	All users	None available.	This is a random Microsoft bug with form loading. Inconsistent and difficult to reproduce.	CR 1,670	Maintenance TBD
Server System Administrator	A VBECS system error will occur when a database timeout occurs. A Database timeout error should be handled by the software.	Low risk /Low impact.	All users	The user should restart VBECS and continue where they left off.	If the database receives numerous queries or save requests simultaneously or there is a high-volume of network traffic, there is the possibility for a database timeout. This means that the database cannot respond to all of the requests in the allotted response time and VBECS error message is generated.	CR 2,113	Maintenance TBD
Server System Administrator	Data corruption can occur when data is inappropriately entered directly into the database.	No identified risk/ No identified impact.	None	None required.	All VBECS unit and patient data must be entered via a user interface. This would result from the administrator accessing the database to enter information. This was discovered during internal system testing and is extremely unlikely to happen in the field without significant disregard for security and policy rules.	CR 2,273	Maintenance TBD
Special Instructions & Transfusion Requirements	When opening the Special Instructions and Transfusion Requirements (SI and TR) option, there is no audible alert for patients with existing entries.	No identified risk/ No identified impact.	All users	None required.	The user is in the option proper, this was a misunderstanding of the requirement for an audible alert associated with the existence of SI and TR.	DR 2,152	Maintenance TBD
Special Instructions & Transfusion Requirements	After a patient has been selected and the SI/TR entry screen appears, the OK button remains enabled.	No identified risk/ No identified impact.	All users	None required.	None	CR 2,078	Maintenance TBD

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Supplies: Log in Supplies	VBECS does not allow a user to select an expired supply item with an override during modification.	No identified risk/ No identified impact.	All users, when selecting an expired supply item to associate with a unit modification.	Do not use an expired supply item.	Standard of practice is to use only in-date supplies. This would be an unusual situation. The lot number can be entered with a different expiration date as a work around if in-date supplies must be used. Supplementary documentation related to the use of an expired supply are required, including a local risk assessment.	CR 1,807	Type III Blood Product Table update
Supplies: Log in Supplies	Log-In Supplies Inventory list view does not sort when column headers are clicked.	No identified risk/ No identified impact.	All users when attempting to sort the list using the column headers.	None required.	None	CR 2,100	Type III Blood Product Table update
Transfu-sion Complicat ions Report	Transfusion Complications report selection criteria indicates that multiple threshold values can be requested for a single test but only the first parameter is used to prepare the report.	No identified risk/ No identified impact.	All users can print the report, but a Supervisor would be responsible for review.	Additional report requests are required if various results thresholds are needed. Example of multiple value names: +, POS, POSITIVE.	The user has to request the report for each possible result individually. Usually there is only one current active value for a test result.	CR 2,247	Report Tool Upgrade Project Proposal
Transfu-sion Complica-tions Report	Transfusion Complications Report has an system error if a numeric threshold value is defined and there is a text result.	No identified risk/ No identified impact.	All users can print the report, but a Supervisor would be responsible for review.	The user will have to request the report without the date of the implicated text test result (e.g., “Canc” for an expected numeric result). VistA tests for the date of the text result can be viewed in VistA.	The user may screen the test in question using VistA. This report is used as a look back tool, not a pretransfusion assessment.	CR 2,252	Report Tool Upgrade Project Proposal
Transfu-sion Complica-tions Report	VBECS cannot be queried for data in a date range occurring prior to VBECS installation.	No identified risk/ No identified impact.	All users can print the report, but a Supervisor would be responsible for review.	The user must include a VistA report request for dates prior to VBECS installation.	The existing VistA report is used for data retrieval prior to the production use of VBECS. VistA blood bank reports remain available for retrieval.	CR 2,255	Report Tool Upgrade Project Proposal
Transfus-ion Effective-ness Report	Lab Test Name displays the VistA short name for the test.	No identified risk/ No identified impact.	All users can print the report, but a Supervisor would be responsible for review.	None required.	The user should be familiar with this test name. If they are not, they would query VistA.	CR 2,135	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Transfusion Effectiveness Report	When requesting the Transfusion Efectiveness Report when no data is found the message "No information is available, per entered search criteria" displays.	No identified risk/ No identified impact.	All users can print the report, but a Supervisor would be responsible for review.	None required.	This is consistent with design.	DR 2,539	Report Tool Upgrade Project Proposal
Transfusion Effectiveness Report	The report scheduler does not schedule prints on the same date.	No identified risk/ No identified impact.	All users can print the report, but a Supervisor would be responsible for review.	Select to print on a future day. For example, a user must queue a report to print data from the previous day.	The report is available for on demand printing. This prevents the user from creating a partial report for the date requested.	CR 2,136	Report Tool Upgrade Project Proposal
Transfusion Reaction Count Report	Ordered and pending transfusion reaction workups are not included in the report.	No identified risk/ No identified impact.	All users can print the report but a Supervisor would be responsible for review.	None required.	These are incomplete tests. Only finalized TRW are included in the report.	CR 1,974	Report Tool Upgrade Project Proposal
Transfusion Reaction Count Report	Transfusion Reaction Count Report will include one or all Divisions for the report.	No identified risk/ No identified impact.	All users can print the report but a Supervisor would be responsible for review.	None required.	The report includes a single division or all of the divisions in the consolidated database. The option to select a subset of the consolidated divisions is not available.	DR 2,602	Report Tool Upgrade Project Proposal
Transfusion Reaction Count Report	Hardcopy of Summary Report does not print "Page x of y" at bottom right page.	No identified risk/ No identified impact.	All users can print the report, but a Supervisor would be responsible for review.	View the Report on screen. "Page x of y" appears at the bottom right of page.	The page numeration is not centered	CR 2,216	Report Tool Upgrade Project Proposal
Transfusion Reaction Count Report	Date Range uses the date the Transfusion Reaction Work Up (TRW) was entered, rather than the Date Reaction Noted as set in Patient Testing: Enter Transfusion Reaction Workup.	No identified risk/ Low impact.	All users can print the report, but a Supervisor would be responsible for review.	The search terms for the Transfusion Reaction Count Report use the last date the TRW was updated, and the "Date Reported" is found in the details of the report.	The TRW may or may not be included in the count if it was updated after the date reported and that is used for the report selection.	CR 2,220	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Transfu-sion Reaction Count Report	The first page of the report is blank except for the header, title and section header.	No identified risk/ No identified impact.	All users can print the report but a Supervisor would be responsible for review.	None required.	The report information begins on the second page and is accurately displayed.	CR 2,221	Report Tool Upgrade Project Proposal
Transfu-sion Reaction Count Report	Hovering a mouse over a report produces tool tips that are meaningless.	Low risk /Low impact.	All users can print the report, but a Supervisor would be responsible for review.	None required.	No incorrect information is displayed. The tool tips are related to Crystal Reports section names of the report. This does not interfere with the contents of the report.	CR 2,223	Report Tool Upgrade Project Proposal
Transfu-sion Reaction Count Report	The transfusion reaction report does not display the component class of the implicated unit.	No identified risk/ No identified impact.	All users can print the report but a Supervisor would be responsible for review.	The product code of the implicated unit is displayed on the report. The component class of the unit can be determined by reviewing the Unit History Report for the implicated unit.	The user would have to look up the component class if it is an unfamiliar product code.	DR 2,690	Report Tool Upgrade Project Proposal
Transfu-sion Require-ments Report	Transfusion Requirements Report does not work with the report scheduler.	No identified risk/ No identified impact.	All Users can print the report, but a Supervisor would be responsible for review.	Users must run the report when needed.	The report is available for on demand printing.	CR 2,257	Report Tool Upgrade Project Proposal
Transfu-sion Require-ments Report	The partial report displays patient blood types and Transfusion Requirements. The cumulative report does not display ABO/Rh when there is no other requirement.	Low risk /Low impact.	All users can print the report but a Supervisor would be responsible for review.	To create a report with all patients' blood types and Transfusion Requirements, print a partial report with the date range from VBECS implementation through the current date.	The user must request the report using the workaround. If a cumulative report format is selected only patients with transfusion requirements and antibodies are displayed, not all patients on file.	CR 1,971	Report Tool Upgrade Project Proposal
Transfu-sion Require-ments Report	A report printed with an end date of today does not print "Preliminary" in the header.	No identified risk/ No identified impact.	All users can print the report but a Supervisor would be responsible for review.	Check the subsequent pages of the report and write "PRELIMINARY" on the front page of the report prior to filing.	The information included in the report is accurate to the time printed. There is a possibility of a gap of information should the user not overlap the print requests. Generally, this report is printed for the day prior or time period that does not include the current day.	CR 1,969 DR 2,584	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Transfu-sion Require-ments Report	The Transfusion Requirements report prints all divisions; no option to print selected divisions.	No identified risk/ No identified impact.	All users can print the report but a Supervisor would be responsible for review.	None required.	The patient files are available at this level to all divisions in the consolidated database. This is a disconnect between the written rule and the desired information handling.	DR 2,605	Report Tool Upgrade Project Proposal
Transmit Workload Data	User will get the "No workload code defined. Workload credit cannot be applied to this transaction." warning message (if appropriate) when you cancel an order.	No identified risk/ No identified impact.	None	None required.	Setup requires that workload codes be assigned. Canceling an order has no specific workload associated with it. This does not impact billable tests.	CR 2,236	Maintenance TBD
Unit Antigen Typing	If the database connection is lost in the milliseconds between testing result save and testing worklist update, the worklist may not be updated as Completed. If the worklist has been Completed but not updated, attempting to access it from the worklist listing will cause a VBECS system error, and the user will need to restart VBECS, and should not invalidate this worklist from the Unit Antigen typing function.	Very Low risk /Low impact.	All users	When invalidating a worklist, it is suggested that the user access the worklist to confirm that it is actually Incomplete before invalidating it.	Rare occurrence. Invalidations should be made in the Edit Unit Information function.	CR 2,109	Testing Grids
Unit Antigen Typing	When a user cancels out of an antigen testing worklist without performing any testing and then creates a new worklist for the same antiserum lot number; VBECS does not display the control cells on this worklist.	No identified risk/ No identified impact.	All users	When the intent is to recreate the worklist for the same antiserum lot number, perform the control test when it is displayed whether or not the selected units are tested.	The user invalidates this worklist and begins again.	CR 1,585	Testing Grids
Unit Antigen Typing	A system error occurs when a user enters reagent lot numbers, uses the Backspace key to erase one of multiple entries, and clicks OK.	Low risk /Low impact.	All users	Reenter the reagent lot numbers.	The user must log back into VBECS. This has been identified as a training issue. When the user highlights and retypes the lot number this does not occur.	CR 1,572	Testing Grids
Unit Antigen Typing	VBECS saves the test grid when the user's lock expires (timeout), so it becomes a partially completed worklist even if no results were recorded.	No identified risk/ No identified impact.	All users	Complete the partially completed testing or use the red X button to clear the results from the grid.	This may be a benefit as the user has allowed a timeout to occur without saving their data.	CR 1,574	Testing Grids

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Unit Antigen Typing	VBECS displays "Unit was issued and results indicate a possible patient conflict. Notify the physician of this potential problem IMMEDIATELY, per hospital policy!" when a unit was emergency issued prior to the completion of testing and an antigen negative requirement is subsequently identified. The expected message is “Units have been emergency issued. Notify the physician of this potential problem IMMEDIATELY, per hospital policy!"	No identified risk/ No identified impact.	All users	None required.	The intent of the message is the same. The message is grammatically different from the written business rule but is materially equivalent.	CR 1,575	Testing Grids
Unit Antigen Typing	VBECS does not display testing comments entered for the control cells when partially completed testing is recalled.	No identified risk/ No identified impact.	All users	Testing comments are properly displayed in the Testing Worklist Report.	None	CR 1,744	Testing Grids
Unit Antigen Typing	When a duplicate antigen test is performed on a unit that does not match the original, VBECS displays a message that does not exactly match the expected message.	No identified risk/ No identified impact.	All users	None required.	VBECS correctly displays the message for antigen typing discrepancies when the discrepancy is due to an update as well as login or testing. The message is grammatically different from the written business rule but is materially equivalent.	CR 1,830	Testing Grids
Unit Antigen Typing	The error message delivered differs from the expected message for the “IS/RT X X” test pattern with an interpretation of I (inconclusive).	No identified risk/ No identified impact.	All users	Enter viable testing results.	This pattern is invalid. The message is grammatically different from the written business rule but is materially equivalent.	CR 1,984	Testing Grids
Unit Antigen Typing	Unable to enter pattern “IS/37” as “X/P” respectively with a “P” interpretation.	Low risk /Low impact.	All users	None available.	The user must enter a test value of N or P in IS (Immediate Spin).	CR 2,484	1.6.0.0
Unit History Report	When a user retroactively updates a unit status through the Discard or Quarantine option, the Unit History Report displays the updated information, but does not display the date the change was made.	No identified risk/ No identified impact.	All users	None available.	None	DR 2,020	Report Tool Upgrade Project Proposal
Unit History Report	The Unit History report Costs column displays the incorrect cost if units are pooled.	No identified risk/ No identified impact.	All users	See the Cost Accounting Report for cost of Splits/Divides and Pools.	None	CR 2,158	Report Tool Upgrade Project Proposal
Unit History Report	If a unit is entered in inventory, shipped via Outgoing Shipment, and reentered in inventory via Incoming Shipment; the Unit History Report includes incomplete Outgoing Shipment information on the Incoming Shipment page.	No identified risk/ No identified impact.	All users	The correct information appears on the Unit History Report but the duplicated display of outgoing shipment information may require investigation.	None	CR 1,607	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Unit History Report	When a unit is added, the Unit History Report for a pooled unit displays duplicate targets for that unit.	No identified risk/ No identified impact.	All users	None required.	Although duplicated, the correct modification information is included in the report.	CR 1,880	Report Tool Upgrade Project Proposal
Unit History Report	The Unit History report does not indicate the CMV status correctly if a unit was re-entered into VBECS without a CMV negative status. This only occurs if the unit was originally entered with the CMV negative status.	Very Low risk / Very Low impact.	All users when re-entering a CMV negative unit.	None required.	VBECS correctly retrieves the unit's original information and considers the unit CMV negative for selection and issue. If the unit CMV testing status changed and is no longer considered negative at the time of reentry, clear the CMV negative special testing check box in Edit Unit Information.	CR 1,932	Report Tool Upgrade Project Proposal
Unit History Report	VBECS displays the five-digit blood product code in the Report Criteria section of the report.	No identified risk/ No identified impact.	All users	None required.	The full product code is displayed properly in the header of the report.	CR 1,989	Report Tool Upgrade Project Proposal
Unit History Report	VBECS displays the user ID rather than the user name in the Transfusion Information Processed By column.	No identified risk/ No identified impact.	All users	None required.	The user is identifiable though this is not the usual presentation.	CR 1,943	Report Tool Upgrade Project Proposal
Unit History Report	The column header reads "Crossmatched By" instead of "Released By."	No identified risk/ No identified impact.	All users	Information displayed in this column is clearly unit release information when taken in the context of the entire report.	This is misleading as a header but follows the issue information so is logically located for the user.	CR 2,008	Report Tool Upgrade Project Proposal
Unit History Report	Unit History Report section of the report has the word "antigen" spelled incorrectly.	No identified risk/ No identified impact.	All users	None required.	There is a typographical error.	CR 2,114	Report Tool Upgrade Project Proposal
Unit History Report	In the Unit History Report, Patient Association section, the Crossmatched to Patient Name and Assigned to Patient Name may not have a space between the first and middle name depending on the length of the patient's names.	No identified risk/ No identified impact.	All users	None required.	There is a typographical error.	CR 2,116	Report Tool Upgrade Project Proposal
Unit History Report	When there are inactivated blood units in the VBECS system, an additional redundant Select Units window appears when attempting to create a Unit History Report.	No identified risk/ No identified impact.	All users	None required.	The second window must be closed to proceed.	CR 2,084	Report Tool Upgrade Project Proposal
Unit History Report	Tested By column is blank for Unit Antigen Typing.	No identified risk/ No identified impact.	All users	See the Testing Worklist Report for the tested by user name.	This is a secondary report for this information.	CR 2,180	Report Tool Upgrade Project Proposal

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Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Unit History Report	Antigen typing interpretations from Incoming Shipment, Edit Unit Information, or testing are presented as the antigen status only on pick lists throughout VBECS.	No identified risk/ No identified impact.	All users	None required.	Unit testing information is found on the Unit History Report and the Testing Worklist Report. This relates to pick lists not the blood availability report which would be used to search for type specific units. Assigning units to match patient requirements is not impacted.	DR 1,640	Report Tool Upgrade Project Proposal
Unit History Report	The Unit History Report does not display when a unit has been Returned to Shipper or Shipped to Another Facility.	No identified risk/ No identified impact.	All users	The Cost Accounting Report contains this information.	This is a secondary report for this information.	DR 1,641	Report Tool Upgrade Project Proposal
Unit History Report	Unit History Report, Transfusion Reaction Count Rpt: Transfusion Information section: Patient. The patient prints twice in the Transfusion Information section. Once with the correct treating specialty, (e.g., HEMATOLOGY/ONCOLOGY) and once with a blank treating specialty.	No identified risk/ No identified impact.	All users	None required.	Correct information is duplicated.	CR 2,281 CR 2,282	Report Tool Upgrade Project Proposal
VBECS Adminis-trator	User A is defined in only one division. User B is defined in three divisions. If the administrator enters User B's DUZ in the configure user function for User A, User A will now have access to all the divisions that User B had.	Low risk /Low impact.	System Administrator	Clear all fields between user configurations. Do not share a DUZ number among users.	Configure VBECS users using the technical manual-security guide and local requirements for staff assignment to VBECS divisions. Unique DUZ must be used for each VBECS user. This may be different from current local policy.	CR 1,902	1.5.0.0
VBECS Adminis-trator	Use of the same DUZ for multiple users is not allowed.	No identified risk/ No identified impact.	System Administrator	None required.	The DUZ is the unique identifier of the user in the VBECS database. The site wanted to reuse the DUZ of an inactivated user. This cannot be done with VBECS users as it will lead to data corruption. Facility policy review during installation to ensure convention is followed.	CR 2,451	Maintenance TBD
VBECS Adminis-trator	If a Windows NT login ID becomes inactive and is eligible for re-use in Active Directory, do not re-use it for VBECS when that NT login ID already has been used in VBECS. Reports containing records for work performed by the inactive VBECS user will present with active user's name or ID.	No identified risk/No identified impact	System Administrator as they cannot reuse NT login or DUZ when activating a VBECS user.	Each VBECS user whether inactive or active must have a unique Windows NT login ID.	A unique NT login ID is required for each VBECs user. This may be different from current local policy.	CR 2,259	Maintenance TBD

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VBECS Adminis-trator	The radio button for selecting multidivisional reports is enabled in a single division.	No identified risk/No identified impact	System Administrator	None required.	The button is enabled and may be selected; data are retrieved appropriately only from the division where access is granted for the user. There is no impact to the business process as selecting that option retrieves the information for divisions defined in the database of which there is only one.	CR 1,990	Maintenance TBD
VBECS Adminis-trator	Facility Name Field does not allow a full view of the registration number and full name of the selected facility.	No identified risk/ No identified impact	System Administrator	None required.	The user can read the FDA registration number which is the unique identifier for the facility. The FDA registration number is not editable where the Name may be edited. The FDA registration number is the unique identifier for a facility.	CR 2,340	Maintenance TBD
VBECS Adminis-trator	Clicking the Clear button after saving any changes still displays a warning about discarding changes that were made to the division details.	Low risk /Low impact.	System Administrator	None required.	The user must reject this errant message and save their changes. The user has the option to reject the message and save the details.	CR 2,344	Maintenance TBD
VBECS Adminis-trator	The tool tip message for the disabled Clear button is incorrect. It states "Click to erase changes and reset screen." Expected to state "The data on the screen were not changed".	No identified risk/No identified impact	System Administrator	None required.	The message is incorrect but is rarely viewed by a user. The button is disabled and cannot be selected in either case.	CR 2,348	Maintenance TBD
VBECS Adminis-trator	Entering a space before the IP value in any of the IP address fields leads to a system error rather than presenting the error message.	No identified risk/No identified impact	System Administrator	None required.	Entering a space anywhere else in the IP address fields leads to the normal error message. Entering any other leading character before the IP value in the IP address fields, such as letters or symbols, leads to the normal error message. Installation process requirement that leads to questions but no erroneous actions.	CR 2,370	Maintenance TBD
VBECS Adminis-trator	A user can configure a VistA Institution as a division and an associated institution. Orders placed at that CBOC to be rejected at acknowledgment. The user is alerted to the error in configuration by this message: “Unable to find valid Associated Institutions information. Please check configuration.”	Low risk /No identified impact.	System Administrator	None required.	This is corrected during configuration verification during validation testing.	CR 2,376	Maintenance TBD
VBECS Adminis-trator	Message purge behavior as described is not working.	No identified risk /Low impact.	System Administrator	None required.	The system administrator must manually clear the system message logs.	CR 2,410	Maintenance TBD

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
VBECS Adminis-trator	VBECS rejects a merge message if the "merge from" or "merge to" patient has a DFN of 2147483648 or greater. VBECS does not display any information regarding the VistA merge.	Low risk/Low impact.	System Administrator	The VBECS preproduction readiness review evaluates each VistA database for patient DFNs that exceed the VBECS merge message DFN size limit to determine which sites are impacted.	Impacted sites may be delayed or evaluated for specific workarounds as the likelihood of occurrence is limited. Evaluation prior to proposed installation so site can evaluate if they have patient records with this rare feature.	CR 2,462	1.5.0.0
VBECS Adminis-trator	When a user's name is entered in Active Directory without a space between the comma and first name, the first letter of the first name is not displayed in VBECS Administrator Edit Users.	No identified risk/No identified impact	System Administrator	None required.	The surname and other information that clearly identifies the user are available.	CR 2,366	1.5.0.0
VBECS Adminis-trator	Missing message: "A Default Form Printer must be chosen."	Low risk /Low impact.	System Administrator	None required.	User is unable to proceed until the printer is identified. This would occur during system validation in test and should be corrected at that time. It should not be an issue in the production installation.	DR 2,937	VBECS BCE Interface Project
Workload Codes (Division Configu-ration)	Invalidating split units will result in negative workload equal to the number of splits created applied to the total number of units logged in.	No identified risk/ No identified impact.	All users When split modification is enabled at the facility.	None available.	This occurs when split units are incorrectly processed in VBECS.	CR 2,224	Maintenance TBD
Workload Codes (Division Configu-ration)	Workload totals for VBECS processes may not match the VistA workload report totals. Repeat orders are known only to VBECS so if workload is generated as a result of a repeat order test the VBECS workload report will include that workload in its totals but the VistA workload report will not.	No identified /Low impact.	All users	None required.	Compare the workload code number totals that are equivalent.	CR 2,240 CR 2,244	Maintenance TBD
Workload Codes (Division Configu-ration)	The view of selectable workload items is displayed on the right when the option opens. Not all of the information is immediately viewable.	No identified risk/ No identified impact.	All users	None required.	All of the information can still be seen (by scrolling).	CR 2,111	Maintenance TBD
Workload Codes (Division Configu-ration)	LMIP/NLT associated CPT codes are not changed by checking or unchecking the boxes.	No identified risk/ No identified impact.	Administrator	Adjust the LMIP/NLT code to CPT code associations in VistA Lab.	This has been identified as a training issue.	CR 2,438	Maintenance TBD

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number)

Option Where the Issue Occurs	Description	Risk Assessment /Impact to Patient Care	Security Role Mitigations (Affected User)	Recommended Workaround	Additional Comments	Tracking System Number*	Tentative Schedule
Workload Codes (Division Configu-ration)	Generation of ABO/Rh confirmation workload at the same time as Warning or Valid tests creates extra records on the WorkloadEvent table. This workload is being transmitted to VistA, without an associated BloodUnitGuid to associate the workload to a unit.	No identified risk/ No identified impact.	None	None	This is inconsistent to the intended design but is invisible to the clinical application user as it is not associated with a blood unit record.	CR 2,425	1.5.0.0

*CR (Code Request Tracking System Number), DR (Document Request Tracking System Number)